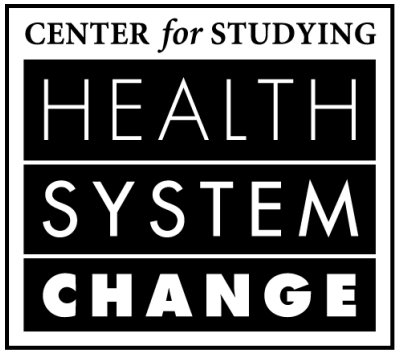
**Community Tracking Study**

# 2004-05 Physician Survey Public Use File: User's Guide

**(Release 1)**

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**Community Tracking Study (CTS)**
**2004-05 Physician Survey**
**Fact Sheet**

| Survey Details | |
|---|---|
| Sample | 6,628 physicians in the contiguous U.S. providing direct patient care for at least 20 hours per week, excluding federal employees, specialists in fields in which the primary focus is not direct patient care, and foreign medical school graduates who are only temporarily licensed to practice in the U.S. The sample is clustered in 60 communities. Among the 6,628 physicians, 4,428 also appeared in the data from the Round Three (2000-01) survey, providing a panel sample (for users of the Restricted Use File only). |
| Time period | June 2004 – July 2005 |
| Content | Basic information on practice, specialty, and board certification<br>Career satisfaction<br>Physician time allocation, productivity<br>Patient case mix: chronic conditions, race, ethnicity<br>Practice arrangements and ownership<br>Availability of IT in practice<br>Care management strategies and gatekeeping<br>Hospital safety<br>Ability to provide quality care<br>Inability to obtain needed services for patients<br>Cost sharing<br>Acceptance of new patients<br>Practice revenue<br>Compensation<br>Race/ethnicity<br>Importance of factors that may limit quality care |
| Differences between the 2004-05 (Round Four) and 2000-01 (Round Three) surveys | While core items were retained, the instrument was revised substantially. The main differences are listed below. See Chapter 2 for details on other differences. Appendix B lists which variables are available for each year.<br><br>Some questions dropped for the 2004-05 survey:<br>• Number of practices<br>• Board eligibility<br>• Medical information obtained by patients from other sources<br>• Other owners of practice<br>• Number of nurse practitioners, etc.<br>• Practice acquired in last two years<br>• Practice preferences<br>• Internet access<br>• Effect of profiling, patient satisfaction surveys on practice of medicine<br>• PCP change in scope of care (Specialists' views)<br>• Specialist scope of care questions<br>• Level of communication with specialists/PCPs<br>• Whether practice is accepting new capitated patients<br>• Whether profiles are risk-adjusted<br>• Percent income from bonuses |

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**Community Tracking Study (CTS)**
**2004-05 Physician Survey**
**Fact Sheet – *continued***

| **Survey Details *(continued)*** | |
|---|---|
| Differences between the 2004-05 (Round Four) and 2000-01 (Round Three) surveys - *continued* | Some questions added to the 2004-05 survey:<br>• Number of patient visits in different settings (PCPs only)<br>• Location of charity care<br>• Case mix: chronic conditions, race/ethnicity group, language communication problems<br>• Level of nursing support<br>• Clinical data exchange with hospitals and labs<br>• Use of IT for information on drug interactions<br>• Percent of prescriptions written electronically<br>• CPOE, medical error reporting<br>• Percent hospitalized patients served by hospitalist<br>• Inability to obtain specific services (revised base question)<br>• Cost-sharing for privately insured patients<br>• Reasons not accepting new Medicare or Medicaid patients<br>• Importance of factors, including financial performance of practice, on compensation<br>• Importance of factors that may limit quality care |
| Terminology | The CTS Physician Survey has been conducted periodically since 1996-97.<br>"Round One" refers to the 1996-97 survey.<br>"Round Two" refers to the 1998-99 survey.<br>"Round Three" refers to the 2000-01 survey.<br>"Round Four" refers to the 2004-05 survey. |
| **Types of Estimates** | |
| Geographic areas represented | These data are designed to allow the user to calculate nationally representative estimates. In addition, users of the Restricted Use File can calculate estimates for the 60 selected communities. |
| Estimates for 2004-05 | These data can be used for calculating cross-sectional estimates representing the period 2004-05. |
| Change estimates (cross-sectional and panel) | The data from the 2004-05 survey can be combined with data from the earlier rounds (1996-97, 1998-99, and 2000-01) to calculate the difference across rounds. In addition, users of the Restricted Use File can combine the 2004-05 data with data from the 2000-01 survey to calculate estimates of change at the physician level for the panel sample of physicians. |
| Pooled estimates | To benefit from increased sample size, data from multiple years of the Physician Survey can be combined to calculate a single "pooled" estimate. |

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**Community Tracking Study (CTS)**
**2004-05 Physician Survey**
**Fact Sheet - *continued***

| Using the Data Files | |
|---|---|
| Obtaining the data files and documentation | The data files and documentation are available through the Inter-University Consortium for Political and Social Research (ICPSR). The web site is www.icpsr.umich.edu.<br><br>The Public Use File can be downloaded at no cost directly from the ICPSR web site. The Restricted Use File is available to approved users only and is available at no or nominal fee. ICPSR provides the restricted data file on CD. To obtain permission to use the Restricted Use File, users must comply with conditions listed in the CTS Physician Survey Restricted Data Use Agreement, such as limiting data access to people specified in the agreement and destroying the data upon completion of the specified research project. Copies of the agreement and a description of the application process are available from the ICPSR web site. |
| Differences between the Public Use File and the Restricted Use File | The Public Use File contains less detailed information than the Restricted Use File in order to preserve the confidentiality of the survey respondents. The two files contain the same number of observations, but the Public Use File has fewer variables, some of which have undergone more extensive editing than those on the Restricted Use File. The Public Use File doesn't contain information on the geographical area of the physician's practice. It also doesn't contain the information necessary for using statistical software programs that account for the complex survey design, which means that it cannot be used for calculating standard errors and is therefore appropriate only for preliminary analysis. Lastly, only the Restricted Use File contains information that allows the user to identify physicians that are part of both the 2004-05 (Round Four) and 2000-01 (Round Three) samples. |
| **Contacting the CTS help desk** | **ctshelp@hschange.org** |

## 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 User's Guide gives researchers the information necessary for using the public use version of the data file containing information from the 2004-05 Physician Survey.

Data collection for the 2004-05 Physician Survey began in June 2004 and was completed in July 2005. Earlier versions of the survey were conducted in 1996-97, 1998-99, and 2000-01. 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.

This User's Guide presents background information about the CTS and the 2004-05 Physician Survey, explains how to calculate nationally representative estimates from the data, and discusses the correct approach to estimating variances. This discussion is followed by a description of variable construction and editing and other information about the data file. The appendices contain additional information (the survey instrument and a list of the variables on the Physician Survey data files by year). The codebook (*Community Tracking Study 2004-05 Physician Survey Public Use File: Codebook)* provides more detail on the data file, including frequencies and definitions of variables.

## ACKNOWLEDGMENTS

The Center for Studying Health System Change (HSC) would like to express its great appreciation to its contractors, Mathematica Policy Research, Inc. (MPR) and Social and Scientific Systems, Inc. (SSS), for their collaboration in the production of this User's Guide and the accompanying codebook and data file.

## 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 and restricted use 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 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) 2004-05 Physician Survey Public Use 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). Additional documentation and detailed information on the file layout and content are available in *Community Tracking Study 2004-05 Physician Survey Public Use File: Codebook.* 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 and Appendix C). Of these communities ("sites"), 12 have been 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." Because of cost constraints, however, the 2004-05 Physician Survey sample design did not include oversampling of the 12 "high

[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.

intensity" sites, unlike previous rounds.[3] As a result, the small number of cases within some sites means that estimates for individual sites may not be reliable or suitable for publication.

## 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, 2000-01, and 2003. The Physician Survey was conducted in 1996-97, 1998-99, 2000-01, and 2004-05.

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.[4]

Case studies in the 12 high-intensity sites make up the qualitative component of the CTS. The first five 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 fifth round was conducted in 2005. The findings are available from HSC.[5]

[3] The exclusion of the oversampling of the 12 "high intensity" sites and the reallocation of the sample among all 60 sites resulted in a more efficient sampling design and the reduction in the overall sample size was largely offset by this increased sample efficiency. The precision afforded by this reduced sample size is only slightly less than that available from the larger samples in the prior surveys

[4] 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.

[5] 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) | |

Notes:
1) The numbers listed above are site identifiers and are provided in the Restricted Use data file as the variable SITEID.
2) "High-Intensity Sites" were not oversampled in the 2004-05 Physician Survey.

## 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 tracing 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. Gallup and MPR assisted in the development of the new items for subsequent surveys, including cognitive testing. Social and Scientific Systems, Inc. (SSS) was instrumental in converting the raw survey data into data files suitable for analysis. MPR, SSS, and HSC collaborated to prepare the documentation for the public and restricted use files.

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. Appendix A provides a copy of the questionnaire. Differences between the questionnaires for 2000-01 (Round Three) and 2004-05 (Round Four) are described in Chapter 2.

The survey was administered completely by telephone, using computer-assisted telephone interviewing technology. Interviews with 6,628 physicians were completed between June 2004 and July 2005.

The sample frame was developed by combining lists of physicians from the American Medical Association (AMA) and the American Osteopathic Association (AOA). The sample consisted of a combination of those who were part of the 2000-01 sample and physicians that had not been included in earlier samples. There were 4,428 physicians who responded to both the 2000-01 and 2004-05 surveys.[6]

## 1.4. PHYSICIAN SURVEY PUBLIC USE FILE AND RESTRICTED USE FILE

Two versions of the CTS Physician Survey physician-level data files are available to researchers: the Restricted Use File and the Public Use File. 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 Inter-University Consortium for Political and Social Research (ICPSR) web site at www.icpsr.umich.edu.

[6] Refer to the Round Four Methodology Report for more information on the survey sample (HSC Technical Report No. 70).

The Restricted Use File is provided to researchers for use on only a specific research project (new applications would be required for subsequent analyses using the data) 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. Researchers are encouraged to review documentation for both the public and restricted use files, available from ICPSR at www.icpsr.umich.edu, as well as the requirements of the *Community Tracking Study Physician Survey Restricted Data Use Agreement,* before deciding which file will meet their needs.

The ***Public Use File*** is available from ICPSR and can be downloaded directly from the ICPSR Web site. Researchers need not specifically apply for use of the Public Use File. Unlike the Restricted Use File, the Public Use File does not contain information on physician practice location (i.e., which of the 60 CTS sites) and so 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 (see below). Note that, unlike the Restricted Use File, the Public Use File does not contain information that allows the user to identify the panel sample of physicians who are part of both the 2000-01 and 2004-05 samples. 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.

Researchers who are interested only in means for Physician Survey variables for the 60 sites should obtain the ***Physician Survey Summary File***. The data file and documentation can be downloaded directly from the ICPSR Web site.

As stated above, the Public Use File does not contain certain data that are available on the Restricted Use File. Other variables on the Public Use File were modified somewhat to ensure the confidentiality of survey respondents. These modifications are described in Chapter 5. Appendix B lists the variables available on the public and restricted use versions of the data files for all the years of the Physician Survey. In that list, a different name for the same variable on the public and restricted use files indicates that the data for this variable underwent additional editing for confidentiality in the public use version.

# 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. The Physician Survey was administered to a sample of physicians in the 60 CTS sites.[7] The survey's sample design makes it possible to develop estimates at the national and community (site) levels.

For the first three rounds of the CTS Physician Survey, interviews were administered to physicians in the 60 CTS sample sites and to an independent national sample of physicians, referred to as the "national supplement." To reduce the cost of the Round Four 2004-05 Physician Survey, the national supplement was eliminated and the sample among the 60 CTS sites was reallocated among the sites more closely proportional to the number of physicians represented by each site. In addition, the sample allocation was adjusted to achieve approximately equal samples of primary care providers and specialists. Otherwise, the design of the 2004-05 sample was similar to prior rounds, retaining a nationally representative 60-site sample design.

The analysis of survey data from the CTS's sample design is more complex than it would be if a simpler sample design were used. Chapter 3 explains how to choose the sample and weighting variables appropriate for your analysis.

## 2.1. THE PHYSICIAN SURVEY SAMPLE

We randomly selected physicians within each CTS 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 later surveys, we obtained sample frames from the AMA and the AOA but selected the sample ourselves.

We randomly selected physicians within each CTS 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 later surveys, we again obtained sample frames from the AMA and the AOA but we selected the sample ourselves because of the greater complexity introduced by establishing a panel survey component to the sample design.

In the 2004-05 Physician Survey, the sample design involved randomly selecting both physicians who were part of the 2000-01 survey and physicians who were not. 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. Because of our goal for cross-sectional analysis for each survey, we included

[7] See Appendix C for information on the selection of the CTS sites.

physicians who were not part of the previous survey's sample frame (as well as physicians who were part of the previous survey's sample, but did not complete the interview) to ensure representation of all eligible physicians. In the final sample of physicians for 2004-05, about 70 percent were included in the 2000-01 survey sample.

### 2.1.1. Eligible Physicians

As the source for our sampling frame, we obtained the November 2003 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,[8] be practicing in the contiguous United States, and be providing direct patient care for at least 20 hours per week.[9] 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[10]
- Federal employees
- Graduates of foreign medical schools who are only temporarily licensed to practice in the United States

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.

### 2.1.2. 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. The physician's location for sampling purposes was determined by the AMA/AOA preferred mailing address. 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 status and disposition relative to the 2000-01 survey, and the plan resulted in 8 strata

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

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

[10] 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.

in each site.[11] The sample allocated to each site was more directly proportional to the number of physicians represented by each site and with two restrictions: (a) each site was allocated a sample size expected to result in at least 100 completed interviews among physicians practicing in the site or (b) if the number of physicians in a site was small, all physicians were included in the sample.

### 2.1.3. 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. These ineligible physicians are not included on the file.

## 2.2. SURVEY CONTENT

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 Appendix A. No proxy respondents were allowed for the Physician Survey. All physicians responded to the interview for themselves.

[11] 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 the 2000-01 sample frame; in the 2000-01 sample frame but not sampled for the 2000-01 survey; sampled for 2000-01 but did not complete the 2000-01 interview; and completed the 2000-01 interview).

TABLE 2.1

CONTENTS OF THE 2004-05 PHYSICIAN SURVEY

| Topic | Description |
|---|---|
| **Basic Practice Information / Specialty and Certification / Career Satisfaction (Questionnaire Section A)** | |
| Eligibility for survey | Federal employee<br>Less than 20 hours/week<br>Excluded specialty |
| Practice information | Location of primary practice<br>Year began medical practice |
| Specialty and certification | Primary specialty<br>Board certification |
| Satisfaction | Current level of satisfaction with overall career in medicine |
| **Physician Time Allocation / Case Mix (Questionnaire Section B)** | |
| Weeks worked | Number of weeks practiced medicine in 2003 |
| Hours worked during last complete week of work | Hours worked in medicine during last complete week of work<br>Hours spent in direct patient care during last complete week of work<br>Number of patient visits in office, outpatient clinics, etc. (PCPs) |
| Charity care in the last month | Hours spent in charity care in the last month<br>Location of charity care |
| Case mix | Percentage of patients with chronic conditions<br>Race/ethnicity of patients<br>Difficulty communicating due to language differences |
| **Practice Arrangements and Ownership (Questionnaire Section C)** | |
| Ownership of practice | Respondent ownership |
| Practice description | Type of practice<br>Quality/level of nursing support |
| Financial incentives and competitive situation | Effect of financial incentives on quantity of services<br>Competitive situation of practice |

See Appendix B for a list of specific variables available on the public use and restricted use data files.

TABLE 2.1

CONTENTS OF THE 2004-05 PHYSICIAN SURVEY
(Continued)

| Topic | Description |
|---|---|
| **Computer Use / Medical Care Management Strategies / Gatekeeping (Questionnaire Section D)** | |
| Access to clinical IT in medical practice | Access to computers or other forms of information technology:<br>Treatment guidelines<br>Formularies<br>Preventive service reminders<br>Patient notes<br>Prescriptions<br>Exchange of clinical data with other physicians<br>Exchange of clinical data with labs, hospitals<br>Email patients<br>Identify drug interactions<br>Percentage of prescriptions written electronically |
| Medical care management | Percentage of patients with prescription drug formulary<br>Effect of practice guidelines on practice of medicine<br>Computerized order system for tests and medications in hospital<br>Anonymous medical error reporting system in hospital<br>Percentage of hospitalized patients with hospitalist |
| PCP Scope of Care | Percentage of patients for whom physician acts as gatekeeper<br>Change in severity or complexity of patients' conditions for which care is provided without referral to specialists<br>Change in number of referrals made |
| **Practice Styles of Primary Care Physicians (Questionnaire Section E)** | |
| No Section E in the 2004-05 survey. | |

See Appendix B for a list of specific variables available on the public use and restricted use data files.

TABLE 2.1

CONTENTS OF THE 2004-05 PHYSICIAN SURVEY
(Continued)

| Topic | Description |
|---|---|
| **Ability to Provide Care / Ability to Obtain Needed Services for Patients / Acceptance of New Patients (Questionnaire Section F)** | |
| Perceptions of ability to provide quality care | Adequate time to spend with patients<br>Freedom to make clinical decisions<br>Providing high-quality care<br>Making clinical decisions without negative effect on income<br>Maintaining continuing patient relationships |
| Inability to obtain needed services for patients | Inability to obtain:<br>Referrals<br>Hospital admissions<br>Diagnostic imaging<br>Outpatient mental health care<br>Reasons for difficulties obtaining:<br>Referrals<br>Hospital admissions<br>Outpatient mental health care |
| Cost sharing (privately insured patients) | Impact of insured patient out-of-pocket costs on:<br>Prescription of generic vs. name brand drugs<br>Diagnostic tests<br>Selection of out-patient vs. in-patient care |
| Acceptance of new patients | Practice accepts:<br>New Medicare patients<br>New Medicaid patients<br>New privately insured patients<br>New uninsured patients unable to pay<br>Reasons practice not accepting all or most:<br>New Medicare patients<br>New Medicaid patients |
| **Practice Revenue (Questionnaire Section G)** | |
| Public programs | Percentage of practice revenue from Medicare<br>Percentage of practice revenue from Medicaid or other public insurance |
| Managed care | Percentage of practice revenue that is capitated/prepaid<br>Number of managed care contracts<br>Percentage of practice revenue from managed care |

See Appendix B for a list of specific variables available on the public use and restricted use data files.

TABLE 2.1

CONTENTS OF THE 2004-05 PHYSICIAN SURVEY
(Continued)

| Topic | Description |
|---|---|
| **Physician Compensation and Race/Ethnicity (Questionnaire Section H)** | |
| Physician compensation | Whether physician is salaried<br>Physician eligible to earn bonus or incentive income<br>Factors used by practice to determine compensation<br>Importance of factors in determining compensation |
| Income | Net income from practice of medicine in 2003 |
| Race/ethnicity | Hispanic origin<br>Race |
| Ability to provide care | Factors affecting ability to provide high quality care:<br>Inadequate time with patients during office visits<br>Patients inability to pay for needed care<br>Rejections of care decisions by insurance companies<br>Lack of qualified specialists in area<br>Not getting timely reports from other physicians/facilities<br>Difficulties communicating due to language/cultural barriers |

See Appendix B for a list of specific variables available on the public use and restricted use data files.

### 2.2.1. Changes in the Physician Survey Questionnaire

While core items were retained, the questionnaire used for the 2004-05 survey was revised substantially from previous surveys. The main changes made for the 2004-05 survey are listed below. The User's Guides for the earlier public and restricted use data files describe the differences between those surveys. In addition, Appendix B provides a table listing which variables are on the data files for which years.

***Items dropped from the 2004-05 survey***

- Number of practices; board eligibility [Section A]
- Information brought by patients [Section B]
- Other owners of practice; number of nurse practitioners, etc.; practice acquired in last two years; practice preferences [Section C]
- Internet access; effect of profiling and patient satisfaction surveys on practice of medicine; effect of care management tools on ability to provide efficient and high quality of care; PCP change in scope of care; specialist scope of care [Section D]
- Level of communication with specialists/PCPs; acceptance of new capitated patients [Section F]
- Whether profiles are risk adjusted; eligibility for bonuses/percent income from bonuses [Section H]

***Items added to the 2004-05 survey***

- Number of patient visits in different settings (PCPs); location of charity care; case mix: chronic conditions, race/ethnicity group, language communication problems [Section B]
- Level of nursing support compared to three years ago [Section C*]
- IT clinical data exchange with hospitals and labs; IT used to obtain information on drug interactions; percentage of prescriptions written electronically; CPOE, Medical errors (asked of specialists and also PCPs with hospital visits); percent hospitalized patients with hospitalist [Section D]
- Inability to obtain specific services (and reasons); cost sharing; reasons not accepting new Medicare/Medicaid patients [Section F]
- End of year compensation adjustments; role of overall financial performance of practice on compensation; importance of factors affecting compensation; importance of factors that may limit ability to provide high quality care [Section H*]

* Also, some questions moved from other sections; changes in skip patterns

## 2.3. 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 June 2004 and July 2005.

The total number of completed interviews was 6,628 with a weighted response rate among eligibles of 52.4 percent.

Physicians were sent advance letters from the Robert Wood Johnson Foundation and were offered a $25 honorarium for participating in the survey. .

# CHAPTER 3

## USING THE PHYSICIAN SURVEY PUBLIC USE FILE

The Physician Survey was designed to be used for a variety of types analyses. Table 3.1 lists the types of estimates that can be calculated and also shows the different capabilities of the public and restricted use data files. Note that the Public Use File can be used only for making nationally representative estimates (excluding analyses that require knowledge of the physician's practice location). In addition, only the Restricted Use File contains the information necessary for correct calculation of variance estimates, and so the Public Use File is recommended only for preliminary investigation of the data to help decide whether to obtain the Restricted Use File.

TABLE 3.1

ANALYTIC CAPABILITIES OF THE
2004-05 PHYSICIAN SURVEY DATA FILES

| Capabilities | Public Use File | Restricted Use File |
|---|---|---|
| **Type of analysis** | | |
| Site-specific estimates (see Notes below) | no | yes |
| National estimates: analysis without physician location | yes | yes |
| National estimates: analysis with physician location | no | yes |
| Panel sample: national estimates of physician-level change | no | yes |
| **Correct variance estimates** | no | yes |

Notes:

1) See Chapter 3 of the Restricted Use File User's Guide for a detailed discussion of the different types of analyses.

2) The 2004-05 Physician Survey sample design did not include oversampling of the 12 "high intensity" sites, unlike previous rounds. As a result, site-level estimates can be used in multi-variate analyses but estimates for individual sites may not be reliable or suitable for publication.

## 3.1. CAPABILITIES AND LIMITATIONS OF THE PUBLIC USE FILE

Because of confidentiality concerns, the Public Use File has less information than the Restricted Use File, which limits the types of analyses for which it can be used (see Table 3.1).

- The Public Use File has no site identifiers, which means that the data cannot be used to make site-specific estimates. Similarly, the data cannot be used for analyses of the national physician population that require information on physician practice location.

- The 2004-05 Public Use File has no identifiers indicating the physicians who were also in the 2000-01 survey, and so the data cannot be used for analyses of changes that physicians experienced between the two periods.

- The Public Use File has no variables with the sample design information that is necessary for calculating variance estimates correctly. (Chapter 4 explains why information on the sample design is needed.)

Despite these limitations, the Public Use File can still be useful for preliminary investigation of the Physician Survey data before acquiring the Restricted Use File. Specifically, if you would like to calculate nationally representative estimates for 2004-05 and do not need to control for physician practice location, the Public Use File provides exactly the same point estimates (e.g., means, proportions, regressions coefficients) as the Restricted Use File.

In addition to simple national estimates for 2004-05, the Public Use File data can be combined with the data from the other years of the Physician Survey to do preliminary investigation for other types of analyses. You can calculate national estimates of change between 2004-05 and 2000-01, 1998-99 or 1996-97, and you can also pool the data from 2004-05 with one or more of the other years to benefit from larger sample size. See Chapter 3 of the User's Guide for the Restricted Use File for more discussion of analyses involving multiple years of the Physician Survey data.

## 3.2. CALCULATING ESTIMATES WITH THE PUBLIC USE FILE

The Public Use File is a physician-level file with 6,628 records (one per physician). To produce nationally representative estimates, you need to use the weight variable WTPHY4**,** which is the only weight on the file. Using WTPHY4 and the full sample of physicians generates nationally representative estimates for all physicians in the survey population (physicians in the contiguous U.S. providing direct patient care for at least 20 hours per week, excluding federal employees, specialists in fields in which the primary focus is not direct patient care, and foreign medical school graduates who are only temporarily licensed to practice in the U.S.)

As mentioned above, the Public Use File will generate correct weighted point estimates, but correct variance estimates require information that is contained only in the Restricted Use File.

# CHAPTER 4

## DERIVING APPROPRIATE VARIANCE ESTIMATES

Some element of uncertainty is always associated with sample-based estimates of population characteristics because the estimates are not based on the full population. This sampling error is generally measured in terms of the standard error of the estimate, or its sampling variance, which is an indicator of the precision of an estimate.[12] Estimates of the standard errors are necessary to construct confidence intervals around estimates and to conduct hypothesis tests.

Specialized techniques are required for estimating sampling variances in the CTS Physician Survey because of the complex sample design. Like many other large national surveys, the sample design for the Physician Survey is not a simple random sample. Instead, the sample design uses stratification, clustering, and oversampling to provide the basis for making national estimates (see Chapter 2 for a description of the sample design). The Physician Survey therefore has a design-based sampling variance, meaning that the sampling variance estimate is a function of both the population parameter being estimated and the sample design.

Departures from a simple random sample design result in a "design effect" (*Deff*), which is defined as the ratio of the sampling variance (*Var*) given the actual survey design to the sampling variance of a hypothetical simple random sample (*SRS*) with the same number of observations. Thus:

$$Deff = \frac{Var\ (actual\ design\ with\ n\ cases)}{Var\ (SRS\ with\ n\ cases)}$$

A design effect equal to one means that the design did not increase or decrease the sampling variance relative to a simple random sample. A design effect of greater than one means that the design increased the sampling variance; that is, it caused the estimate to be less precise. A design effect of less than one means that the net effect of the sample design was to decrease the variance (i.e., to make the estimate more precise).

Because most of the estimates from the CTS Physician Survey have a design effect greater than 1.0, it is important to account for the survey design when calculating variance estimates. This means that you need to have variables that capture the sample design (these variables are often referred to as "sampling parameters"), and you also need specialized statistical software that is able to use the information from the sampling parameters in the variance estimation procedures. The sampling parameters for the Physician Survey are available only on the Restricted Use File, which is why the Public Use File is recommended only for preliminary analysis. For a discussion of how to use various statistical software packages to estimate sampling variances for the Physician Survey, see Chapter 4 of the User's Guide for the Restricted Use File.

[12]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. The classical population variance is a measure of the variation among the population, whereas a sampling variance is a measure of the variation of the *estimate* of a population parameter (for example, a population mean or proportion) over repeated samples. The population variance is different from the sampling variance in the sense that the population variance is a constant, independent of any sampling issues, whereas the sampling variance becomes smaller as the sample size increases. The sampling variance is zero when the full population is observed, as in a census.

# CHAPTER 5

# VARIABLE CONSTRUCTION AND EDITING

The CTS Physician Survey Public Use File contains three types of variables: unedited variables, edited variables, and constructed variables created from edited or unedited variables.[13] This chapter provides a general description of the types of constructed and edited variables in the file, as well as additional details on selected variables.

The information in this chapter supplements the information provided in the "Description" field of the file's codebook. Users are encouraged to review this information along with the questionnaire provided in Appendix A for a better understanding of the questionnaire structure, skip patterns, and other characteristics of the variables reported on the file.

## 5.1. EDITED VARIABLES

The CTS Physician Survey data were collected via computer-assisted telephone interviewing (CATI). The CATI editing functions included consistency checks and editing of some skip patterns and outlier values. This section describes the editing that followed the CATI data collection, including logical editing, imputation of missing values, and editing for confidentiality. Verbatim text responses were also reviewed and coded.

### 5.1.1. Logical Editing

Logical editing was performed to resolve inconsistencies among related variables and to resolve skip pattern inconsistencies. For example, question A6 (YRBGNX), pertaining to the year the physician began practicing medicine, was asked of all physicians. There were cases where the reported year in which the physician began to practice was before his/her reported year of medical school graduation. In these cases, the value for YRBGNX was changed to make it three years later than the graduation year (for primary care physicians) or five years later than the graduation year (for specialists). (As described below, after the aforementioned edits, YRBGNX and GRADYRX were recoded into five-year intervals for confidentiality reasons).

Logical editing also included review and resolution of inconsistencies after data imputation was performed.

[13] In general, unedited variables are those that contain the original response to a single questionnaire item.

### 5.1.2. Imputation of Missing Values

Missing values for selected variables were imputed using unweighted and weighted sequential hot-deck imputation.[14] Variables were selected for imputation according to their level of missing data and analytic importance. For some variables, the imputation process for physicians in the panel sample made use of data for those physicians from the 2000-01 survey.[15] Table 5.1 lists the variables selected for imputation and their nonresponse rates.

An imputation flag is included for most variables with imputed values. A value of "1 Imputation" for the imputation flag indicates that the value of the corresponding variable was imputed. For confidentiality reasons, imputation flags are not included for variables that were masked. The imputed variables without flags are:

- Weeks practicing medicine in 2003 (WKSWRKX)
- Hours in the previous week devoted to medically related activities (HRSMEDX)
- Hours in the previous week devoted to patient activities (HRSPATX)
- Hours in the previous month devoted to charity care (HRFREEX)
- Number of physicians in practice (NPHYSX)
- Net income in 2003 (INCOMEX)
- Percent of patients that are Asian or Pacific Islander (ASIAPTX)
- Percent of patients that are African-American or Black (BLCKPTX)
- Percent of patients that are Hispanic(HISPPTX)
- Percent of hospitalized patients with hospitalist (HSPLSTX)
- Number of managed care contracts (NMCCONX)

The definition of the imputation flag for PMC (the percent of practice revenue from managed care) has been changed for Round Four. In prior rounds, the imputation flag identified imputed values for practices that received managed care revenues but did not report managed care contracts. The Round Four definition was expanded to also identify imputed values for practices that reported having managed care contracts. The change was made to make the imputation flag _PMC consistent with the percentage revenue variable PMC.

[14]In sequential hot-deck imputation, persons with missing values, or "recipients," are linked to persons with available values, or "donors," to fill in the missing data. The donors and recipients are first classified into strata and then sorted within each strata using classification/sort variables such as gender, PCP status, and year when physician began practicing medicine. (The number of strata is limited by a minimum donor-to-recipient ratio that must be satisfied within each stratum). Donors are then assigned to recipients with similar characteristics within their stratum. In weighted hot-decking, donor and recipient weights are used to help determine the assignment of donors to recipients so that means and proportions calculated using the imputed data will equal means and proportions obtained using only donor data. In general, weighted hot-decking was performed for data with more than 5 percent missing values.

[15] On the Public Use File, those variables are PMCAID, PMCARE, HRFREEX, PMC, and PCAPREV.

TABLE 5.1

IMPUTED VARIABLES ON THE 2004-05 PHYSICIAN SURVEY PUBLIC USE FILE

| Description | Variable Name | Nonresponse Rate[a] |
|---|---|---|
| **Section B:** | | |
| Weeks worked | WKSWRKX | < 1% |
| Hours worked in medical activities | HRSMEDX | < 1% |
| Hours worked in patient care | HRSPATX | < 1% |
| Hours worked in charity | HRFREEX | 9% |
| Percent of patients that are Asian or Pacific Islander | ASIAPTX | 1% |
| Percent of patients that are African-American or Black | BLCKPTX | 1% |
| Percent of patients that are Hispanic | HISPPTX | 1% |
| Location of charity care | LOCFREE | 6% |
| **Section C:** | | |
| Ownership status | OWNPR | < 1% |
| Number of physicians | NPHYSX | <1% |
| Influence of financial incentives on services | INCENT | 4% |
| **Section D:** | | |
| Percent of patients for whom physician is gatekeeper | PCTGATE | 3% |
| Patients with prescription coverage with formulary | FORMLRY | 12% |
| Awareness of formal written guidelines | AWRGUID | 12% |
| Percent of hospitalized patients with hospitalist | HSPLSTX | 3% |
| **Section F:** | | |
| Accepting Medicare patients | NWMCARE | 9% |
| Accepting Medicaid patients | NWMCAID | 3% |
| Accepting privately insured patients | NWPRIV | 3% |
| Accepting uninsured patients unable to pay | NWNPAY | 5% |
| **Section G:** | | |
| Percent Medicare revenue | PMCARE | 17% |
| Percent Medicaid revenue | PMCAID | 15% |
| Percent captitated revenue | PCAPREV | 17% |
| Number of managed care contracts | NMCCONX | 33% |
| Percent of practice revenue from managed care | PMC | 20% |
| **Section H:** | | |
| Income | INCOMEX | 18% |

[a] Imputation rate among applicable cases for that variable.

### 5.1.3. Editing for Confidentiality

Some data in the Public Use File have been manipulated or edited to ensure the confidentiality of survey respondents while maximizing the scope of data released to the public. This type of editing consisted of such steps as excluding variables and constructing new variables based on original ones. All cases of editing for confidentiality are described in the file's codebook in either the "Format" field or the "Description" field. Variables subjected to confidentiality editing have been assigned names ending with "X."

#### 5.1.3.1. Variable Exclusion

All geographic information has been removed from the Physician Public Use File. In addition, we excluded any variables that could serve to identify an individual physician. Examples include: the type of doctor – MD or DO (doctor of osteopathy) – and the country from where the physician graduated medical school. Survey questions or constructed variables that had very small cell sizes were also excluded because these variables may uniquely describe individual physicians. Finally, we excluded all sample design parameters and weights except for one weight to be used for making national estimates. This was done because the sample design parameters describe geographic information and the other weights are for site-specific purposes.

#### 5.1.3.2. Masking of Minimum and Maximum Values

Extreme and relatively rare cases that fell at the top or bottom of a distribution were recoded to a lower/higher value, which is referred to as "top-coding" or "bottom-coding" in the Format and Description fields in the codebook. For example, the variable corresponding to question B1 (WKSWRKX, number of weeks practicing medicine in 2003) reflects the use of bottom-coding. Reported values less than 40 have been combined into a single category, "40 (bottom code)." Physician income (INCOMEX) serves as another example of this type of masking. Reported income was converted to a categorical variable with intervals of $50,000 and top-coded at $300,000. We do not recommend calculating a mean for variables that have been top-coded and/or bottom-coded.

#### 5.1.3.3. Constructing New Variables

For confidentiality reasons, new variables were constructed by combining several original variables, by collapsing values of a categorical variable, or by collapsing values for a continuous variable into categories. When survey questions identified relatively rare populations, a new variable was constructed by combining the rare cases into one or more broad groups. For a single categorical variable, one or more values were combined.

For example, SPECX, which describes the physician's specialty, was constructed by combining the responses to questions A8 (physician's specialty) and A10 (physician's subspecialty). Responses to A8 and A10 included over 200 possible values. These specialties were collapsed into seven categories of specialty in SPECX.

### 5.1.4. Editing Verbatim Responses

For several questionnaire items, respondents were allowed to provide "other" verbatim responses when none of the existing response categories seemed to apply. Although these verbatim responses are excluded from the Public Use File, many of them were reviewed and coded into an appropriate existing or new categorical value.

## 5.2. CONSTRUCTED VARIABLES

Constructed variables include the following:

- Weight (WTPHY4)
- Other variables constructed for analytical value. These are variables that combine one or more original question items for the convenience of analysts.

Constructed variables are indicated in the file's codebook by a value of "N/A" (Not Applicable) in the "Question" field. Information on how they were constructed appears in the "Description" field. Table 5.2 contains additional background on some of the more complex constructions.

## 5.3. IDENTIFICATION AND FRAME VARIABLES

Not all variables on the Public Use File were obtained directly from survey respondents via the CATI questions. Additional variables include the physician identifier and other survey administration variables relating to demographic information from the sample frame.

- The physician identifier variable on the Public Use File is called PHYSIDX.

- The following variables contain demographic information from the sample frame from the American Medical Association (AMA) and the American Osteopathic Association (AOA): IMGUSPR (foreign medical school graduate), GRADYRX (year graduated from medical school), GENDER (gender), and BIRTHX (year of birth).

## 5.4. ADDITIONAL DETAILS ON SELECTED SURVEY VARIABLES

Table 5.2, organized by questionnaire section, provides "helpful hints" about variables (singly or in sets), discusses a variable's relationship with other variables, and suggests when to use a specific variable. This information supplements the variable-specific details contained in the file's codebook.

There has been a major change to one series of questions and associated variables included in both the 2000-01 and the 2004-05 surveys: the base question regarding the respondent's ability to obtain needed services (referrals, non-emergency hospital care, diagnostic imaging, outpatient mental health services) was changed significantly. Comparisons between 2004-05 estimates and previous rounds are not meaningful for these variables. We have changed the 2004-05 variable names to prevent confusion. Moreover, the change in the base question also means that the universe of respondents asked about reasons for not being able to obtain a given service (referrals, non-emergency hospital care, outpatient mental services) is different in 2004-05 than

previously. Even though the variable names in 2004-05 are similar to those in 2000-01, comparisons between rounds are also not meaningful for these variables.

To find out whether there were any minor changes to a variable that you are using, you should review the codebooks.

TABLE 5.2

ADDITIONAL INFORMATION ON SURVEY QUESTIONS
BY QUESTIONNAIRE SECTION

| Variable | Additional Information |
|---|---|
| **Section A Variables: Introduction** | |
| YRBGNX | YRBGNX is the masked version of the Restricted Use File variable YRBGN. YRBGN comes from question A6, which asks for the year that the physician began medical practice.<br><br>Examination of certain responses to this question indicates that some respondents replied with the number of years in practice rather than the actual year commencing practice. For these cases, YRBGN was set to the interview year minus the initial response to question A6.<br><br>For physicians who did not respond to this question or for whom his/her medical school graduation year occurred after the reported value for YRBGN, YRBGN was reset to graduation year + 3 for primary care physicians and graduation year + 5 for specialists. If graduation year was also missing, then YRBGN was set to be BIRTH + 30 for primary care physicians and BIRTH + 32 for specialists. |
| PCPFLAG | PCPFLAG is a constructed flag variable that indicates whether the physician is a primary care physician (PCPFLAG=1) or a specialist (PCPFLAG=0). The variable is constructed based on responses to questions A8, A10, A9, A9a, and A9b.<br><br>PCPFLAG=1 if the physician's specialty (A8 or A10) is one of the following:<br>Family practice (019)<br>Geriatric medicine (020, 043)<br>General practice (023)<br>Adolescent medicine (085, 133)<br><br>OR if the physician's specialty (A8) is one of the following:<br>Internal medicine (042)<br>Pediatrics (088)<br>Internal medicine – pediatrics (137)<br>Internal medicine – family practice (195)<br>AND the physician spends most of his/her time in one of those specialties [(A9=1) or (A9=2 and A10 = 042, 088, 137, or 195)]<br><br>OR if the physician is an adult specialist and spends more time practicing general internal medicine than his/her subspecialty (A9a=2 or 3)<br><br>OR if the physician is a pediatric specialist and spends more time practicing general pediatrics than his/her subspecialty (A9b=2 or 3)<br><br>PCPFLAG is the survey definition for primary care physician. There is another flag on the file, AMAPRIM, which also indicates primary care status based on the AMA/AOA sample frame data. AMAPRIM=1 for primary care physicians and 0 for specialists and may differ from PCPFLAG. |

TABLE 5.2

ADDITIONAL INFORMATION ON SURVEY QUESTIONS,
BY QUESTIONNAIRE SECTION
(Continued)

| Variable | Additional Information |
|---|---|
| SPECX | SPECX is a constructed variable based on responses to questions A8 (physician's specialty) and A10 (physician's subspecialty). The two survey questions are combined into one variable and then divided into categories according to the type of specialty. The grouping of specialties is as follows. The numbered codes were created for the survey based on AMA and AOA physician specialty classifications. The following specialty codes are new for the 2004-05 survey: 401, 403, 404, 406, and 408.<br><br>1: Internal Medicine<br>042: Internal medicine<br>043: Geriatric medicine<br>085: Adolescent medicine - family practice<br>195: Internal medicine – family practice<br><br>2: Family/General Practice<br>019: Family practice<br>020: Geriatrics-general/family<br>023: General practice<br>403: Family medicine<br><br>3: Pediatrics<br>088: Pediatrics<br>133: Adolescent medicine<br>137: Internal med- pediatrics<br><br>*(continued on next page)* |

TABLE 5.2

ADDITIONAL INFORMATION ON SURVEY QUESTIONS,
BY QUESTIONNAIRE SECTION
(Continued)

| Variable | Additional Information |
|---|---|
| SPECX | *(continued from previous page)*<br><br>4: Medical Specialties<br>001: Allergy<br>002: Allergy & Immunology<br>004: Immunology<br>008: Critical care-Anesthesiology<br>009: Cardiovascular Disease-Cardiology<br>012: Dermatology<br>015: Emergency Medicine<br>016: Sports Medicine-Emergency Medicine<br>017: Pediatric Emergency Medicine<br>021: Sports Medicine-Family/Gen. Practice<br>022: Gastroenterology<br>024: Preventive Medicine<br>035: Diabetes<br>036: Endocrinology<br>037: Hematology<br>038: Hepatology<br>039: Cardiac Electrophysiology<br>040: Infectious Diseases<br>041: Clinical & Laboratory Immunology<br>044: Sports Medicine<br>045: Nephrology<br>046: Nutrition<br>047: Oncology<br>048: Rheumatology<br>049: Clinical Biochemical Genetics<br>050: Clinical Cytogenetics<br>051: Clinical Genetics<br>052: Clinical Molecular Genetics<br>053: Medical Genetics<br>054: Child Neurology<br>055: Clinical Neurophysiology<br>056: Neurology<br>068: Occupational Medicine<br>086: Pediatric Intensive Care<br>087: Neonatology<br>089: Pediatric Allergy<br>090: Pediatric Endocrinology<br>091: Pediatric Pulmonology<br>092: Pediatric Gastroenterology<br>093: Pediatric Hematology/Oncology<br>094: Clinical & Laboratory Immunology<br>095: Pediatric Nephrology<br>096: Pediatric Rheumatology<br>097: Sports Medicine (Pediatrics)<br>098: Pediatric Cardiology<br>100: Physical Medicine & Rehab<br>116: Pulmonary Diseases<br>120: Neuroradiology<br>123: Radiation Oncology<br>128: Critical Care-Medicine<br>136: Hematology & Oncology<br>142: Pain Medicine [AMA]-Psychosomatic Medicine [AOA]<br>143: Palliative Medicine<br>144: Pediatric Emergency Medicine<br>145: Pediatric Infectious Diseases<br>147: Pulmonary-Critical Care<br>149: Sleep Medicine<br>150: Spinal Cord Injury<br>155: Osteo Manipulative Treat<br>156: Spec Prof in Osteo Manip Med<br>157: Sports Medicine-OMM<br>158: Osteo Manipulative Medicine<br>159: Proctology<br>165: Vascular Medicine<br>193: Pediatric Emergency Medicine<br>194: Interventional Cardiology<br>196: Internal Medicine-Preventive Medicine<br>197: Otology-Neurotology<br>200: Physical Medicine and Rehabilitation (Pediatrics)<br>201: Hospitalists<br>202: AIDS/HIV Specialist<br>210: Developmental Medicine<br>308: Internal Medicine – Emergency Medicine<br>309: Sports Medicine (Phys Med & Rehab) [AMA], Geriatrics-Internal Medicine [AOA]<br>311: Neurology – Physical Medicine & Rehabilitation<br>404: Neurodevelopmental Disability<br><br>*(continued on next page)* |

TABLE 5.2

ADDITIONAL INFORMATION ON SURVEY QUESTIONS,
BY QUESTIONNAIRE SECTION
(Continued)

| Variable | Additional Information |
|---|---|
| SPECX | *(continued from previous page)*<br><br>5. Surgical Specialties<br>011: Colon & Rectal Surgery<br>026: Abdominal Surgery<br>027: Critical Care Surgery<br>029: General Surgery<br>030: Head & Neck Surgery<br>031: Hand Surgery<br>032: Pediatric Surgery<br>033: Traumatic Surgery<br>034: Vascular Surgery<br>058: Critical Care-Neurosurgery<br>059: Neurological Surgery<br>060: Pediatric Neurosurgery<br>061: Gynecological Oncology<br>063: Maternal & Fetal Medicine<br>066: Critical Care-Obstetrics & Gynecology<br>067: Reproductive Endocrinology<br>069: Ophthalmology<br>070: Hand Surgery<br>071: Adult Reconstructive Orthopedics<br>072: Musculoskeletal Oncology<br>073: Pediatric Orthopedics<br>074: Orthopedic Surgery<br>075: Sports Medicine (Orthopedic Surgery)<br>076: Orthopedic Surgery of the Spine<br>077: Orthopedic Trauma<br>078: Facial Plastic Surgery<br>079: Otology<br>080: Otolaryngology<br>081: Pediatric Otolaryngology<br>101: Hand Surgery<br>102: Plastic Surgery<br>124: Cardiothoracic Surgery<br>125: Urology<br>126: Pediatric Urology<br>134: Foot & Ankle Orthopedics<br>146: Pediatric Ophthalmology<br>151: Surgical Oncology<br>152: Transplant Surgery<br>153: MOHS Micrographic Surgery<br>154: Hair Transplant<br>164: Dermatologic Surgery<br>190: Cardiovascular Surgery<br>198: Pediatric Cardiothoracic Surgery<br>401: Cosmetic Surgery<br>406: Oral and Maxillofacial Surgery<br>408: Plastic Surgery within the Head and Neck<br><br>6: Psychiatry<br>010: Pediatric Psychiatry<br>082: Psychiatry<br>083: Psychoanalysis<br>084: Geriatric Psychiatry<br>127: Addictive Diseases<br>132: Addiction Psychiatry<br>192: Pediatrics – Psychiatry – Child and Adolescent<br>312: Psychiatry – Family Practice<br><br>7: Obstetrics/Gynecology<br>062: Gynecology<br>064: Obstetrics & Gynecology<br>065: Obstetrics |

TABLE 5.2

ADDITIONAL INFORMATION ON SURVEY QUESTIONS,
BY QUESTIONNAIRE SECTION
(Continued)

| Variable | Additional Information |
|---|---|
| **Section B Variables: Utilization of Time** | |
| HRSMEDX | HRSMEDX is the masked version of the Restricted Use File variable HRSMED. HRSMED is a constructed variable that defines the number of hours (during the past week) spent in medically related activities. This question could be asked up to three times in three different ways by the CATI system, checking for data consistency each time. HRSMED is constructed from responses to survey questions B2, B3c, and B4. If HRSPAT (the number of hours spent in direct patient activities) was greater than HRSMED, then HRSMED was imputed. |
| HRSPATX | HRSPATX is the masked version of the Restricted Use File variable HRSPAT. HRSPAT is a constructed variable that defines the number of hours (during the past week) spent in direct patient care activities. This question could be asked up to three times in three different ways by the CATI system, checking for data consistency each time. HRSPAT is constructed from responses to survey questions B3, B3d, and B5. If HRSPAT was greater than HRSMED (after imputation of both variables) then HRSPAT was set equal to HRSMED. |

TABLE 5.2

ADDITIONAL INFORMATION ON SURVEY QUESTIONS,
BY QUESTIONNAIRE SECTION
(Continued)

| Variable | Additional Information |
|---|---|
| **Section C Variables: Type and Size of Practice** | |
| TOPOWNX | TOPOWNX is the masked version of the Restricted Use File variable TOPOWNC, which is an edited version of the Restricted Use File variable TOPOWN.<br><br>TOPOWN (type of practice ownership) is a variable that comes from survey question C2.<br><br>TOPOWNC is a constructed variable that is a corrected version of TOPOWN. It is "corrected" or edited by incorporating the response to question C9 that asks if the practice is a group model HMO (or exclusively provides services to a group model HMO). If the physician indicated (from the response to question C9) that he/she works in a practice that is a group model HMO, then TOPOWNC was set equal to "9: Group model HMO". |
| TOPEMPX | TOPEMPX is the masked version of the Restricted Use File variable TOPEMPA, which is related to the Restricted Use File variables TOPEMP and TOPEMPC.<br><br>TOPEMP (type of employer) is a variable that comes from survey question C3.<br><br>TOPEMPC is a constructed variable that is a corrected version of TOPEMP. It is "corrected" or edited by incorporating the response to question C9 that asks if the practice is a group model HMO (or exclusively provides services to a group model HMO). If the physician indicated (from the response to question C9) that he/she works in a practice that is a group model HMO, then TOPEMPC was set equal to "9: Group model HMO".<br><br>TOPEMPA is a constructed variable that combines the responses of TOPEMPC and survey question C3b (EMPTYP). The following values for TOPEMPC and EMPTYP were coded to "1: Other" in TOPEMPA:<br><br>1: Other<br>11: Other insurance<br>14: City, county, state government<br>15: Integrated health<br>16: Freestanding clinic<br>17: Physician practice management<br>18: Community health center<br>19: Management services organization (MSO)<br>20: Physician hospital organization (PHO)<br>21: Locum tenens<br>22: Foundation<br>25: Independent contractor<br>26: Industry clinic |

TABLE 5.2

ADDITIONAL INFORMATION ON SURVEY QUESTIONS,
BY QUESTIONNAIRE SECTION
(Continued)

| Variable | Additional Information |
|---|---|
| PRCTYPE | PRCTYPE is a constructed variable that summarizes the type of practice in which the physician works. It combines information about ownership and employment and is constructed as follows:<br><br>1: Solo/two physician practice — TOPOWNC=solo or two-physician practice OR TOPEMPA=solo or two-physician practice<br><br>2: Group>=three physicians — TOPOWNC=three or more physicians OR TOPEMPA=three or more physicians<br><br>3: HMO — TOPOWNC=Group model HMO or staff Model HMO OR TOPEMPA=Group model HMO or staff Model HMO<br><br>4: Medical school — TOPEMPA=Medical school or university<br><br>5: Hospital based — TOPEMPA=Nongovernment hospital OR TOPEMPA=City, county, state government AND OTHSET(C3a)=hospital<br><br>6: Other — All other responses<br><br>Note that all physicians who work for a state or local government hospital are classified as "Hospital Based" in PRCTYPE but as "Other" in TOPEMPA. |
| GRTYPEX | GRTYPEX is a constructed variable that combines responses to questions C2a, C2b, C2c, C3aa, C3ab, C3ac, C3ca, C3cb, and C3cc for physicians working in a group practice of 3 or more physicians. If the physician's response to C2a , C3aa, or C3ca is that he/she is working in a single-specialty practice, then GRTYPEX=1: Single specialty. Otherwise, GRTYPEX=2: Multi-specialty. |

TABLE 5.2

ADDITIONAL INFORMATION ON SURVEY QUESTIONS,
BY QUESTIONNAIRE SECTION
(Continued)

| Variable | Additional Information |
|---|---|
| **Section G Variables: Practice Revenue** | |
| PCAPREV | PCAPREV is a constructed variable indicating the percent of the practice's total patient care revenue paid on a capitated or other prepaid basis. PCAPREV is constructed from responses to: G3, G7b, G8c, and G8g (questions that asked about percentage of practice revenue paid on a capitated or other prepaid basis). Post imputation edits were performed on this variable as follows:<br><br>Capitated revenue is a subset of managed care revenue.<br>Therefore, if PCAPREV>PMC (percent managed care revenue) and both PCAPREV and PMC were imputed, then PCAPREV was edited to be equal to PMC.<br><br>If there is only one managed care contract and all managed care revenue is capitated revenue, then the capitated revenue must be equal to all managed care revenue. Therefore, if NMCCON (number of managed care contracts)=1<br><br>**AND**<br><br>PCAPREV was imputed and PMC was not imputed<br><br>then PCAPREV was edited to be equal to PMC. |
| PMC | PMC is a constructed variable indicating the percentage of the practice's total patient care revenue obtained from managed care. PMC is constructed from responses to: G7, G7a, G8, G8b, G8f (questions that asked about percentage of practice's revenue that comes from managed care). Capitated revenue is a subset of managed care revenue. Therefore, this variable was edited in the following way:<br><br>a. If PCAPREV (percent capitated revenue)>PMC , then PMC was edited to be equal to PCAPREV.<br><br>In addition, a post-imputation edit was performed:<br><br>b. If PCAPREV>PMC AND PMC was imputed, but PCAPREV was not imputed, then PMC was edited to be equal to PCAPREV. |

# CHAPTER 6

# FILE DETAILS

This chapter provides an overview of the file content and technical specifications for programmers. It also describes the variable naming and coding conventions that were used on the file and that appear in the file's codebook.

## 6.1. FILE CONTENT AND TECHNICAL SPECIFICATIONS

The CTS Physician Survey Public Use File contains 6,628 person records. The unique record identifier and sort key is the variable PHYSIDX. Variables are positioned on the file in the following order:

- Survey administration variables: this group includes identifiers and other variables associated with conducting the survey
- Variables from Sections A-H of the Physician Survey questionnaire: Variables are ordered within each section by related questionnaire item number
- Weight variable

The Public Use File is provided as an ASCII-formatted file with the following technical specifications:

| | |
|---|---|
| File name: | CTSR4PP1.TXT |
| Number of observations: | 6,628 |
| Number of variables: | 137 |
| Logical record length: | 307 bytes |

The file contains a two-byte carriage return/line feed at the end of each record. When you are converting to a PC-SAS file, use the LRECL option to specify the record length to avoid the default PC-SAS record length. If the RECFM=V option is used, the LRECL option must be specified as the logical record length (307). If RECFM=F is used, the LRECL value must be specified as the logical record length plus two (309). Note that if the RECFM option is omitted, then the default option of RECFM=V will be used, and LRECL must be specified as the logical record length (307). When you are converting to an SPSS file, use the "FIXED" option of the DATA LIST command, and read values according to column location specified by the column position after each variable name.

The record layout for this file is provided in the file's codebook.

## 6.2. VARIABLE NAMING CONVENTIONS

In general, a variable name reflects the content of the variable. For the following groups of variables, a naming convention was used to provide additional information on variable content:

- ***Imputation Flags.*** These flags indicate whether a record has an imputed value for the corresponding variable. The flag variable has the same name as the variable it describes, and includes the prefix "_". When reading the data into SPSS, imputation flags contain the prefix "I" because SPSS does not recognize the "_" character. For example, _PMC (or IPMC) is the imputation flag corresponding to the variable PMC. Refer to Chapter 5 for more information on imputation and other types of editing procedures used on the file.
- ***Weight.*** The prefix "WT" is used for the weight variable name.
- ***Masked Variables***. Names of variables that were masked for confidentiality reasons end with the value "X." The variable descriptions contained in the file's codebook indicate whether the variable was masked and provide brief details as to the type of masking performed.

## 6.3. VARIABLE CODING CONVENTIONS

The following coding conventions are used on the file:

| | |
|---|---|
| -1 Inapplicable | Question was not asked because of skip pattern (or physician's response to the question indicated that it was not applicable). |
| -7 Refused | Question was asked and respondent refused to answer. |
| -8 Don't Know | Question was asked and respondent did not know the answer. |
| -9 Not Ascertained | Value was not assigned for any other reason. |

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**HSC Technical Publications are available on the HSC Web site.**
**www.hschange.org**

# Appendix A

# The CTS 2004-05 Physician Survey Instrument

# *CRT*

**HARD COPY REQUIRED**

**FINANCE,RWJ59687**
**F687**
**ROUND #4**

**FIELD FINAL – MAY 26, 2004**
**(Columns are ABSOLUTE)**
**(Revisions 7/13, 9/2)**

THE GALLUP ORGANIZATION

PROJECT REGISTRATION #140157
**THE CENTER FOR STUDYING HEALTH SYSTEM CHANGE (RWJ)**
City Center: Washington, D.C.
Physicians Study - Round #4
Larsen/McComb/Richter
Brenda Sonksen, Specwriter
July, 2004 n=7,000

__X__ APPROVED BY CLIENT

__X__ APPROVED BY PROJECT MANAGER

I.D.#: _____(1-6)

**AREA CODE AND TELEPHONE NUMBER:

_____ _____
_____ (649 - 658)

**INTERVIEW TIME:

_____ _____
_____ (716 - 721)

**(NOTE: All interviews are recorded. The recording begins when the respondent answers the phone. This statement is read after the "Continue" response is entered after the Introduction and before the first question)** This call will be recorded for quality assurance.

1 (Continue)
2 (Refused) - **(Thank and Terminate)** _____(984)

**SPECIALTY: **(Code from fone file)** **(SURVENT NOTE: Show on Introduction screen)**

**SPCLTY**

_____ _____
_____ (55 - 57)

**STATE: **(Code from fone file)**

| | | | |
|---|---|---|---|
| 01 | Alabama - SC | 30 | Montana - W |
| 02 | Alaska - W | 31 | Nebraska - NC |
| 04 | Arizona - W | 32 | Nevada - W |
| 05 | Arkansas - SC | 33 | New Hampshire - NE |
| 06 | California - W | 34 | New Jersey - NE |
| 08 | Colorado - W | 35 | New Mexico - W |
| 09 | Connecticut - NE | 36 | New York - NE |
| 10 | Delaware - SC | 37 | North Carolina - SC |
| 11 | Washington D.C. - SC | 38 | North Dakota - NC |
| 12 | Florida - SC | 39 | Ohio - NC |
| 13 | Georgia - SC | 40 | Oklahoma - SC |
| 15 | Hawaii - W | 41 | Oregon - W |
| 16 | Idaho - W | 42 | Pennsylvania - NE |
| 17 | Illinois - NC | 44 | Rhode Island - NE |
| 18 | Indiana - NC | 45 | South Carolina - SC |
| 19 | Iowa - NC | 46 | South Dakota - NC |
| 20 | Kansas - NC | 47 | Tennessee - SC |
| 21 | Kentucky - SC | 48 | Texas - SC |
| 22 | Louisiana - SC | 49 | Utah - W |
| 23 | Maine - NE | 50 | Vermont - NE |
| 24 | Maryland - SC | 51 | Virginia - SC |
| 25 | Massachusetts - NE | 53 | Washington - W |
| 26 | Michigan - NC | 54 | West Virginia - SC |
| 27 | Minnesota - NC | 55 | Wisconsin - NC |
| 28 | Mississippi - SC | 56 | Wyoming - W |
| 29 | Missouri - NC | | |

_____ _____
_____ (58) (59)

**COUNTY: **(Code from fone file)**

_____ _____
_____ (60 - 62)

## *SECTION A*
## *INTRODUCTION AND SCREENING; LOCATION; BOARD CERTIFICATION; SATISFACTION*

S1. DOCTOR TYPE: **(Code from fone file)**
**DOCTYP**

1 MD
2 DO _____(63)

S1b. REPLICATE NUMBER: **(Code from fone file)**
**REPLICAT**

**[SET BY JOHN SELIX]**

S1c. PANEL: **(Code from fone file)**
**PANEL**

1 New
2 Re-interview
3 Non-respondent _____(64)

**(There are no questions S1d-S1f)**

S2. DOCTOR NAME: **(Code from fone file)**

_____ _____
_____ (65 - 105)

S3. PRIMARY SPECIALTY: **(Code from fone file)**

_____ _____
_____ (55 - 57)

S4. SITE NUMBER: **(Code from fone file)**

_____ _____
_____ (148 - 150)

S5. SITE TYPE: **(Code from fone file)**
**STYPE**

1 High intensity
2 Low intensity/National _____(150)

S6. ZIP CODE: **(Code from fone file)**
**ZIP**

_____ (151 - 155)

S6a. PRESEND CHECK EXPERIMENT: **(Code from fone file)**

**PRECHK**

1 Yes
2 No _____(156)

**(Question Sa deleted)**

**(Question Si deleted)** HOLD _____(1101-1102)

**(SURVENT NOTE: Display Doctor's name at top of screen)**

**(If code 1 or 3 in S1c, Continue;
Otherwise, Skip to Introduction #2)**

---

**INTRODUCTION #1**
**HELLO1**

Hello, Dr. **(name from fone file)**, my name is _____, from The Gallup Organization. A short time ago, you should have received a letter from the Robert Wood Johnson Foundation indicating that Gallup is conducting a national survey of physicians for the Foundation. The survey is part of a study of changes in the health care system in communities across the nation. It concerns how such changes are affecting physicians, their practices, and the health care they provide to their patients.

The interview will take about 20 minutes and we are providing an honorarium of $25 as a small token of our appreciation. All the information you provide will be kept strictly confidential. It will be used in statistical analysis and reported only as group totals. I can conduct the interview now or at any time that's convenient for you.

0 Gatekeeper soft refusal

1 Respondent available - **(Skip to A1)**

2 Gatekeeper not available - **(Set time to call back)**

3 No longer works/Lives here - **(Skip to S8)**

4 Never heard of respondent - **(Skip to S7)**

5 Gatekeeper hard refusal

6 Answering service/Can't ever reach physician at this number - **(Skip to S11)**

7 Physician not available - **(Set time to call back)**

8 Physician soft refusal

9 Physician hard refusal _____(1052)

---

**INTRODUCTION #2**

**HELLO2**

Hello, Dr. **(name from fone file)**, my name is _____, from The Gallup Organization. You should have received a letter from the Robert Wood Johnson Foundation indicating that Gallup would be calling you again to participate in the fourth round of the study of changes in the health care systems in communities across the nation. The study concerns how these changes are affecting physicians, their practices, and the health care they provide to their patients.

The interview will take about twenty minutes, and we are again providing an honorarium of $25 as a small token of our appreciation. All the information you provide will be kept strictly confidential. It will be used in statistical analysis and reported only as group totals. I can conduct the interview now, or at any time that's convenient for you.

0 Gatekeeper soft refusal

1 Respondent available - **(Skip to A1)**

2 Gatekeeper not available - **(Set time to call back)**

3 No longer works/Lives here - **(Skip to S8)**

4 Never heard of respondent - **(Continue)**

5 Gatekeeper hard refusal

6 Answering service/Can't ever reach physician at this number - **(Skip to S11)**

7 Physician not available - **(Set time to call back)**

8 Physician soft refusal

9 Physician hard refusal _____(1052)

S7. **(If code 4 in Introduction, ask:)** I would like to verify that I have reached **(phone number from fone file)**.

**VPHONE**

1 Yes - **(Thank and Terminate; Skip to S11)**

2 No - **(READ:)** I am sorry to have bothered you. - **(Reset to Introduction)**

3 (DK) **(Thank and Terminate; Skip to Directory Assistant)**

4 (Refused) **(Thank and Terminate; Skip to Directory Assistant)** _____(2418)

S8. **(If code 3 in Introduction, ask:)** Dr. **(response in S2)** is a very important part of a medical study for the Robert Wood Johnson Foundation. Do you have the address or telephone number where I can reach (him/her)?

**DIFFADR**

1 Yes - **(Skip to S10)**

2 No/Unknown **(Continue)**
3 (DK) **(Continue)**
4 (Refused) **(Continue)**

5 (Retired) - **(Thank and Terminate)** _____(2419)

S9. **(If code 2, 3, or 4 in S8, ask:)** Do you happen to know if the doctor is still in this area, or is (he/she) in another city?

**WHERE**

1 Same area - **(Thank and Terminate; Skip to S11)**

2 Different city - **(Continue)**

3 (DK) **(Thank and Terminate; Skip to S11)**
4 (Refused) **(Thank and Terminate; Skip to S11)** _____(2420)

S10. **(If code 2 in S9 OR code 1 in S8:)** ENTER PHONE NUMBER AND ADDRESS OR AS MUCH OF IT AS POSSIBLE.

**NWPHONE**

WORK PHONE NUMBER:

_____ _____
_____ (2421 - 2430)

**NWHPHON**

HOME PHONE NUMBER:

_____ _____
_____ (2441 - 2450)

**NWADDR**

STREET ADDRESS:

_____ _____
_____ (2892 - 2931)

**NWCITY**

CITY:

_____ _____
_____ (2591 - 2620)

**NWSTATE**

STATE:

_____ _____
_____ (2431) (2432)

**NWZIP**

ZIP CODE:

_____ _____
_____ (2433 - 2437)

**(All in S10, Thank and Terminate;
Call new number and Reset to Introduction;
If BLANK in WORK PHONE NUMBER and
HOME PHONE NUMBER in S10, Continue)**

S11. ***(FDIRECTA)*** **(If code 1, 3, or 4 in S7, OR code 6 in Introduction, OR code 1, 3, or 4 in S9, OR BLANK in WORK PHONE NUMBER and HOME PHONE NUMBER in S10:) (Call directory assistance for most recent city or area code. Ask for directory assistance using full name from fone file.)**

**(Original phone number from fone file)**

**(Original city from fone file)** or **(CITY from S10)**

**(Name from fone file)**

**DIRPHONE**

1 New number - **(Enter on next screen)**

2 No number/Match - **(Thank and Terminate; Save Case ID)** _____(894)

**(All in S11, call new number, and Reset to Introduction)**

CLOCK:

_____ _____
_____ ( - )

A1. Are you currently a full-time employee of a federal agency such as the U.S. Public Health Service, Veterans Administration, or a military service? **(Probe:)** Do you receive your paychecks from a federal agency? **(If respondent works part-time for a Federal Agency, ask:)** Do you consider this (Federal Agency) your main practice?

**FEDEMP**

1 Yes - **(Continue)**

2 No - **(Skip to A2)**

3 Retired - **(Thank and Terminate, and Set to "Failed Screener")**

4 Out of country **(Thank and Terminate, and Set to "Failed Screener")**

5 Institutionalized **(Thank and Terminate, and Set to "Failed Screener")**

8 (DK) **(Thank and Terminate)**

9 (Refused) **(Thank and Terminate)** _____(1053)

**(If code 1 in A1, READ:)** In this survey, we will not be interviewing physicians who are Federal employees. So it appears that we do not need any further information from you at this time, but we thank you for your cooperation. - **(Thank and Terminate)**

A2. Are you currently a resident or fellow?

**RESFEL**

1 Yes - **(Continue)**

2 No - **(Skip to A3)**

8 (DK) **(Thank and Terminate)**

9 (Refused) **(Thank and Terminate)** _____(1054)

**(If code 1 in A2, READ:)** In this survey, we will not be interviewing physicians who are residents or fellows. So it appears that we do not need any further information from you at this time, but we thank you for your cooperation. - **(Thank and Terminate)**

A3. During a TYPICAL week, do you provide direct patient care for at least twenty hours a week? **(INTERVIEWER NOTE:)** **(If necessary, say:)** Direct patient care includes seeing patients and performing surgery. **(If necessary, say:)** INCLUDE time spent on patient record-keeping, patient-related office work, and travel time connected with seeing patients. EXCLUDE time spent in training, teaching, or research, any hours on-call when not actually working, and travel between home and work at the beginning and end of the work day.

**FULLTIM**

1 Yes - **(Skip to Note before A5)**

2 No - **(Continue)**

8 (DK) **(Thank and Terminate)**
9 (Refused) **(Thank and Terminate)** _____(1055)

**(If code 2 in A3, READ:)** In this survey, we will not be interviewing physicians who typically provide patient care for less than 20 hours a week. So it appears that we do not need any further information from you at this time, but we thank you for your cooperation. **- (Thank and Terminate)**

[Deleted Note]

**(Questions A3a-A4a deleted)**

**(If BLANK in **COUNTY, Skip to A5a; Otherwise, Continue)**

A5. We'd like you to think about the practice location at which you spend the greatest amount of time in direct patient care. Is this practice located in **(county and state from fone file)**? **(INTERVIEWER NOTE: Surgeons should give the location of their office, not the hospital where they perform surgery.)**

**LOCCHK**

1 Yes - **(Skip to Note before A5b)**

2 No **(Continue)**
8 (DK) **(Continue)**
9 (Refused) **(Continue)** _____(2634)

A5a. **(If code 2, 8, or 9 in A5 OR If BLANK in **COUNTY, ask:)** In what county and state is the practice located. (Open ended) **(VERIFY SPELLING)**

DK (DK)
RF (Refused)

**SCNTY**

COUNTY:

_____ (2834 - 2858)

**SSTATE**

STATE:

_____ (2859) (2860)

**(If code 15 or 02 in A5a - State, Continue; Otherwise, Skip to A5b)**

**(READ:)** We are not interviewing physicians in your state at this time. So it appears that we do not need any further information from you, but we thank you for your cooperation. - **(Thank and Terminate)**

A5b. What is the zip code of your practice? (Open ended **and code all five digits of zip code)**

**SZIP**

99998 (DK)
99999 (Refused)

_____ (1618 - 1622)

**(If code 2 in S1c, Skip to A7; Otherwise, Continue)**

A6. In what year did you begin medical practice after completing your undergraduate and graduate medical training? **(INTERVIEWER NOTE: A residency or fellowship would be considered graduate medical training.)** (Open ended **and code all four digits of year)** **(SURVENT NOTE: Force interviewers to enter FOUR DIGITS)**

**YRBGN**

DK (DK)
RF (Refused)

_____ _____ (1623 - 1626)

_____

**(If code 999 in S3, Skip to A8; Otherwise, Continue)**

A7. We have your primary specialty listed as **(response in S3)**. Is this correct? **(If necessary, say:)** We define primary specialty as that in which the most hours are spent weekly.

**SPCCOR**

1 Yes - **(Autocode response in S3 into A8)**

2 No - **(Continue)**

8 (DK) **(Thank and Terminate)**
9 (Refused) **(Thank and Terminate)** _____(1065)

A8. **(If code 2 or BLANK in A7, ask:)** What is your primary specialty? **(If necessary, say:)** We define primary specialty as that in which the most hours are spent weekly. (Open ended **and code from hard copy)**
**(INTERVIEWER NOTE: Probe for codeable response)**

**NWSPEC**

**(If code 1 in S1 [MD-AMA LIST])**

| | | |
|---|---|---|
| 301 | Abdominal Radiology | (AR) |
| 202 | AIDS/HIV Specialist | |
| 001 | Allergy | (A) |
| 133 | Adolescent Medicine Pediatrics | (ADL) |
| 127 | Addiction Medicine | (ADM) |
| 132 | Addiction Psychiatry | (ADP) |
| 002 | Allergy & Immunology | (AI) |
| 003 | Allergy & Immunology/ Diagnostic Laboratory Immunology | (ALI) |
| 005 | Aerospace Medicine | (AM) |
| 085 | Adolescent Medicine (Internal Medicine) | (AMI) |
| 006 | Anesthesiology | (AN) |
| 007 | Pain Management | (APM) |
| 026 | Abdominal Surgery | (AS) |
| 103 | Anatomic Pathology | (ATP) |
| 104 | Bloodbanking/Transfusion Medicine | (BBK) |
| 190 | Cardiovascular Surgery | (CDS) |
| 008 | Critical Care Medicine (Anesthesiology) | (CCA) |
| 050 | Clinical Cytogenetics | (CCG) |
| 191 | Craniofacial Surgery | (CFS) |
| 128 | Critical Care Medicine (Internal Medicine) | (CCM) |
| 086 | Critical Care Pediatrics | (CCP) |
| 027 | Critical Care Surgery | (CCS) |
| 009 | Cardiovascular Disease | (CD) |
| 051 | Clinical Genetics | (CG) |
| 054 | Child Neurology | (CHN) |
| 010 | Child & Adolescent Psychiatry | (CHP) |
| 049 | Clinical Biochemical Genetics | (CCG) |
| 105 | Clinical Pathology | (CLP) |
| 052 | Clinical Molecular Genetics | (CMG) |
| 055 | Clinical Neurophysiology | (CN) |
| 011 | Colon & Rectal Surgery | (CRS) |
| 401 | Cosmetic Surgery | (CS) |
| 124 | Cardiothoracic Surgery | (CTS) |
| 012 | Dermatology | (D) |
| 164 | Dermatologic Surgery | (DS) |
| 013 | Clinical & Laboratory Dermatological Immunology | (DDL) |
| 035 | Diabetes | (DIA) |

A8. (Continued:)

| | | |
|---|---|---|
| 106 | Dermatopathology | (DMP) |
| 014 | Diagnostic Radiology | (DR) |
| 015 | Emergency Medicine | (EM) |
| 308 | Internal Medicine/Emergency Medicine | (MEM) |
| 036 | Endocrinology, Diabetes & Metabolism | (END) |
| 302 | Epidemiology | (EP) |
| 016 | Sports Medicine (Emergency Medicine) | (ESM) |
| 402 | Endovascular Surgical Neuroradiology | (ESN) |
| 140 | Medical Toxicology (Emergency Medicine) | (ETX) |
| 303 | Flex Residents | (FLX) |
| 403 | Family Medicine | (FM) |
| 018 | Forensic Pathology | (FOP) |
| 019 | Family Practice | (FP) |
| 020 | Geriatric Medicine (Family Practice) | (FPG) |
| 078 | Facial Plastic Surgery | (FPS) |
| 021 | Sports Medicine (Family Practice) | (FSM) |
| 022 | Gastroenterology | (GE) |
| 061 | Gynecological Oncology | (GO) |
| 023 | General Practice | (GP) |
| 024 | General Preventive Medicine | (GPM) |
| 029 | General Surgery | (GS) |
| 062 | Gynecology | (GYN) |
| 037 | Hematology | (HEM) |
| 038 | Hepatology | (HEP) |
| 107 | Hematology Pathology | (HMP) |
| 030 | Head & Neck Surgery | (HNS) |
| 136 | Hematology/Oncology | (HO) |
| 070 | Hand Surgery Orthopedics | (HSO) |
| 101 | Hand Surgery Plastic | (HSP) |
| 031 | Hand Surgery | (HSS) |
| 201 | Hospitalists | (HOS) |
| 039 | Clinical Cardiac Electrophysiology | (ICE) |
| 040 | Infectious Diseases | (ID) |
| 004 | Immunology | (IG) |
| 041 | Clinical & Laboratory Immunology (IM) | (ILI) |
| 042 | Internal Medicine | (IM) |
| 194 | Interventional Cardiology | (IC) |
| 043 | Geriatric Medicine (IM) | (IMG) |
| 044 | Sports Medicine | (ISM) |
| 309 | Sports Medicine (Physical Medicine and Rehabilitation) (IM) | (PMM) |
| 129 | Legal Medicine | (LM) |
| 138 | Medical Management | (MDM) |
| 063 | Maternal & Fetal Medicine | (MFM) |
| 304 | Maxillofacial Radiology | (MXR) |
| 053 | Medical Genetics | (MG) |
| 108 | Medical Microbiology | (MM) |
| 195 | Internal Medicine/Family Practice | (IFP) |

A8. (Continued:)

| | | |
|---|---|---|
| 137 | Internal Medicine/Pediatrics | (MPD) |
| 099 | Public Health & General Preventive Medicine | (MPH) |
| 056 | Neurology | (N) |
| 310 | Internal Medicine/Neurology | (MN) |
| 311 | Neurology/Physical Medicine and Rehabilitation | (NPR) |
| 058 | Critical Care Medicine (Neurosurgery) | (NCC) |
| 404 | Neurodevelopmental Disability | (NDN) |
| 045 | Nephrology | (NEP) |
| 057 | Nuclear Medicine | (NM) |
| 109 | Neuropathology | (NP) |
| 087 | Neonatal/Perinatal Medicine | (NPM) |
| 117 | Nuclear Radiology | (NR) |
| 305 | Neurology/Diagnostic Radiology/ Neuroradiology | (NRN) |
| 059 | Neurological Surgery | (NS) |
| 060 | Pediatric Neurosurgery | (NSP) |
| 046 | Nutrition | (NTR) |
| 405 | Neuropsychiatry | (NUP) |
| 071 | Adult Reconstructive Orthopedics | (OAR) |
| 064 | Obstetrics & Gynecology | (OBG) |
| 065 | Obstetrics | (OBS) |
| 066 | OB Critical Care Medicine | (OCC) |
| 134 | Foot & Ankle Orthopedics | (OFA) |
| 068 | Occupational Medicine | (OM) |
| 406 | Oral and Maxillofacial Surgery | (OMF) |
| 072 | Musculoskeletal Oncology | (OMO) |
| 047 | Medical Oncology | (ON) |
| 073 | Pediatric Orthopedics | (OP) |
| 069 | Ophthalmology | (OPH) |
| 074 | Orthopedic Surgery | (ORS) |
| 028 | Other Specialty | (OS) |
| 075 | Sports Medicine (Orthopedic Surgery) | (OSM) |
| 076 | Orthopedic Surgery of the Spine | (OSS) |
| 079 | Otology | (OT) |
| 197 | Otology/Neurotology | (NO) |
| 080 | Otolaryngology | (OTO) |
| 077 | Orthopedic Trauma | (OTR) |
| 082 | Psychiatry | (P) |
| 312 | Psychiatry/Family Practice | (FPP) |
| 313 | Internal Medicine/Psychiatry | (MP) |
| 130 | Clinical Pharmacology | (PA) |
| 147 | Pulmonary Critical Care Medicine | (PCC) |
| 110 | Chemical Pathology | (PCH) |
| 111 | Cytopathology | (PCP) |
| 088 | Pediatrics | (PD) |
| 089 | Pediatric Allergy | (PDA) |
| 306 | Pediatric Anesthesiology (Pediatrics) | (PAN) |
| 098 | Pediatric Cardiology | (PDC) |

A8. (Continued:)

| | | |
|---|---|---|
| 198 | Pediatric Cardiothoracic Surgery | (PCS) |
| 193 | Pediatric Emergency Medicine | (EMP) |
| 090 | Pediatric Endocrinology | (PDE) |
| 145 | Pediatric Infectious Diseases | (PDI) |
| 081 | Pediatric Otolaryngology | (PDO) |
| 091 | Pediatric Pulmonology | (PDP) |
| 192 | Pediatrics/Psychiatry/Child & Adolescent Ps | (CPP) |
| 118 | Pediatric Radiology | (PDR) |
| 032 | Pediatric Surgery | (PDS) |
| 139 | Medical Toxicology (Pediatrics) | (PDT) |
| 144 | Pediatric Emergency Medicine | (PE) |
| 017 | Pediatric Emergency Medicine (Pediatrics) | (PEM) |
| 135 | Forensic Psychiatry | (PFP) |
| 092 | Pediatric Gastroenterology | (PG) |
| 093 | Pediatric Hematology/Oncology | (PHO) |
| 112 | Immunopathology | (PIP) |
| 094 | Clinical & Laboratory Immunology (Pediatrics) | (PLI) |
| 143 | Palliative Medicine | (PLM) |
| 100 | Physical Medicine & Rehab | (PM) |
| 314 | Internal Medicine/Physical Medicine & Rehabilitation | (MPM) |
| 200 | Physical Medicine & Rehabilitation (Pediatrics) | (PMP) |
| 142 | Pain Medicine | (PMD) |
| 407 | Sports Medicine (Physical Medicine and Rehabilitation) | (PMM) |
| 095 | Pediatric Nephrology | (PN) |
| 146 | Pediatric Opthalmology | (PO) |
| 113 | Pediatric Pathology | (PP) |
| 096 | Pediatric Rheumatology | (PPR) |
| 102 | Plastic Surgery/Cosmetic Surgery | (PS) |
| 199 | Pharmaceutical Medicine | (PHM) |
| 307 | Public Health | (PH) |
| 408 | Plastic Surgery within the Head and Neck | (PSH) |
| 097 | Sports Medicine (Pediatrics) | (PSM) |
| 114 | Anatomic/Clinical Pathology | (PTH) |
| 141 | Medical Toxicology (Preventive Medicine) | (PTX) |
| 116 | Pulmonary Diseases | (PUD) |
| 196 | Internal Medicine/Preventive Medicine | (IPM) |
| 083 | Psychoanalysis | (PYA) |
| 084 | Geriatric Psychiatry | (PYG) |
| 119 | Radiology | (R) |
| 067 | Reproductive Endocrinology | (REN) |
| 048 | Rheumatology | (RHU) |
| 115 | Radioisotopic Pathology | (RIP) |
| 120 | Neuroradiology | (RNR) |

A8. (Continued:)

| | | |
|---|---|---|
| 123 | Radiation Oncology | (RO) |
| 121 | Radiological Physics | (RP) |
| 409 | Pediatric Rehabilitation | (RPM) |
| 150 | Spinal Cord Injury | (SCI) |
| 149 | Sleep Medicine | (SM) |
| 151 | Surgical Oncology | (SO) |
| 148 | Selective Pathology | (SP) |
| 033 | Trauma Surgery | (TRS) |
| 152 | Transplant Surgery | (TTS) |
| 125 | Urology | (U) |
| 025 | Undersea Medicine | (UM) |
| 126 | Pediatric Urology | (UP) |
| 131 | Unspecified | (US) |
| 122 | Vascular & Interventional Radiology | (VIR) |
| 165 | Vascular Medicine | (VM) |
| 034 | Vascular Surgery | (VS) |
| 210 | Developmental & Behavioral Pediatrics | (DBP) |
| 159 | Proctology | (PRO) |
| 124 | Thoracic Surgery | (TS) |

997 Other (list) - **(USE VERY SPARINGLY; Thank and Terminate)**

998 (DK) **(Thank and Terminate)**
999 (Refused) **(Thank and Terminate)**

_____ _____
(1066 - 1068)

_____

**(If code 2 in S1 [DO-AOA LIST])**

| | | |
|---|---|---|
| 301 | Abdominal Radiology | AR |
| 202 | AIDS/HIV Specialist | |
| 002 | Allergy and Immunology | AI |
| 003 | Allergy-Diagnostic Lab Immunology | ALI |
| 004 | Immunology | IG |
| 005 | Preventive Medicine-Aerospace Medicine | AM |
| 006 | Anesthesiology | AN |
| 006 | Anesthesiology | CAN |
| 006 | Anesthesiology | IRA |
| 006 | Anesthesiology | OBA |
| 006 | Anesthesiology | PAN |
| 007 | Pain Management | APM |
| 007 | Pain Management | PMR |
| 008 | Critical Care-Anesthesiology | CCA |
| 009 | Cardiovascular Diseases-Cardiology | C |
| 009 | Cardiovascular Diseases-Cardiology | CVD |
| 009 | Cardiovascular Diseases-Cardiology | IC |
| 190 | Cardiovascular Surgery | CDS |
| 191 | Craniofacial Surgery | CFS |
| 010 | Pediatric Psychiatry | CHP |

A8. (Continued:)

| | | |
|---|---|---|
| 010 | Pediatric Psychiatry | PDP |
| 011 | Colon & Rectal Surgery | CRS |
| 012 | Dermatology | D |
| 015 | Emergency Medicine | EM |
| 014 | Diagnostic Radiology | DR |
| 308 | Internal Medicine/Emergency Medicine | MEM |
| 015 | Emergency Medicine | EMS |
| 015 | Emergency Medicine | FEM |
| 015 | Emergency Medicine | IEM |
| 302 | Epidemiology | EP |
| 016 | Sports Medicine (Emergency Medicine) | ESM |
| 017 | Pediatric Emergency Medicine | PEM |
| 303 | Flex Residents | FLX |
| 018 | Forensic Pathology | FOP |
| 019 | Family Practice | FP |
| 019 | Family Practice | UFP |
| 020 | Geriatrics-General or Family Practice | GFP |
| 020 | Geriatrics-General or Family Practice | GGP |
| 021 | Sports Medicine-Family or General Practice | SFP |
| 021 | Sports Medicine-Family or General Practice | SGP |
| 022 | Gastroenterology | GE |
| 023 | General Practice | GP |
| 024 | Preventive Medicine | PVM |
| 025 | Undersea Medicine | UM |
| 026 | Abdominal Surgery | AS |
| 027 | Critical Care-Surgery or Trauma | CCS |
| 027 | Critical Care-Surgery or Trauma | CCT |
| 028 | Other Specialty | OS |
| 029 | Surgery-General | S |
| 030 | Head & Neck Surgery | HNS |
| 031 | Hand Surgery | HS |
| 031 | Hand Surgery | HSS |
| 201 | Hospitalists | |
| 032 | Pediatric Surgery | PDS |
| 033 | Traumatic Surgery | TRS |
| 034 | Vascular Surgery-General or Peripheral | GVS |
| 034 | Vascular Surgery-General or Peripheral | PVS |
| 036 | Endocrinology | END |
| 037 | Hematology | HEM |
| 039 | Cardiac Electrophysiology | ICE |
| 040 | Infectious Diseases | ID |
| 041 | Diag Lab Immunology-Int Med | ILI |
| 042 | Internal Medicine | IM |
| 194 | Interventional Cardiology | IC |
| 195 | Internal Medicine/Family Practice | IFP |
| 042 | Internal Medicine | IP |

A8. (Continued:)

| | | |
|---|---|---|
| 043 | Geriatrics-Internal Medicine | GER |
| 309 | Geriatrics-Internal Medicine | GIM |
| 044 | Sports Medicine (Physical Medicine & Rehabilitation) | PMM |
| 044 | Sports Medicine | ISM |
| 044 | Sports Medicine | PMS |
| 044 | Sports Medicine | RMS |
| 044 | Sports Medicine | SM |
| 045 | Nephrology | NEP |
| 046 | Nutrition | NTR |
| 047 | Oncology | ON |
| 048 | Rheumatology | RHU |
| 050 | Clinical Cytogenetics | CCG |
| 051 | Clinical Genetics | CG |
| 053 | Medical Genetics | IMG |
| 054 | Pediatric or Child Neurology | CHN |
| 054 | Pediatric or Child Neurology | PDN |
| 055 | Clinical Neurophysiology | CN |
| 056 | Neurology | N |
| 310 | Internal Medicine/Neurology | MN |
| 311 | Neurology/Physical Medicine & Rehab | NPR |
| 056 | Neurology | NMD |
| 056 | Neurology | NP |
| 056 | Neurology | NPN |
| 305 | Neurology/Diagnostic Radiology/ Neuroradiology | NRN |
| 057 | Nuclear Medicine | NI |
| 057 | Nuclear Medicine | NM |
| 057 | Nuclear Medicine | NV |
| 058 | Critical Care-Neuro Surgery | NCC |
| 059 | Neurological Surgery | NS |
| 061 | Gynecological Oncology | GO |
| 062 | Gynecology | GS |
| 062 | Gynecology | GYN |
| 063 | Maternal & Fetal Medicine | MFM |
| 304 | Maxillofacial Radiology | MXR |
| 064 | Obstetrics & Gynecology | OBG |
| 064 | Obstetrics & Gynecology | OGS |
| 065 | Obstetrics | OBS |
| 066 | Critical Care-Obstetrics & Gynecology | OCC |
| 067 | Reproductive Endocrinology | RE |
| 068 | Occupational Medicine | OCM |
| 068 | Occupational Medicine | OM |
| 069 | Ophthalmology | COR |
| 069 | Ophthalmology | OAS |
| 069 | Ophthalmology | OCR |
| 069 | Ophthalmology | OGL |
| 069 | Ophthalmology | OPH |
| 069 | Ophthalmology | VRS |

A8. (Continued:)

| | | |
|---|---|---|
| 070 | Hand Surgery-Orthopedic Surg | HSO |
| 071 | Adult Reconstructive Orthopedics | OAR |
| 072 | Musculoskeletal Oncology | OMO |
| 073 | Pediatric Orthopedics | OP |
| 074 | Orthopedic Surgery | AJI |
| 074 | Orthopedic Surgery | OR |
| 074 | Orthopedic Surgery | ORS |
| 075 | Sports Medicine-Orthopedic Surgery | OSM |
| 076 | Orthopedic Surgery-Spine | OSS |
| 078 | Facial Plastic Surgery | OPL |
| 080 | Otolaryngology or Rhinology | OTL |
| 080 | Otolaryngology or Rhinology | OTR |
| 080 | Otolaryngology or Rhinology | RHI |
| 197 | Otology/Neurotology | NO |
| 081 | Pediatric Otolaryngology | PDO |
| 082 | Psychiatry | P |
| 312 | Psychiatry/Family Practice | FPP |
| 313 | Psychiatry/Internal Medicine | MP |
| 083 | Psychoanalysis | PYA |
| 084 | Geriatric Psychiatry | PYG |
| 085 | Adolescent Medicine-Family or General Practice | AFP |
| 085 | Adolescent Medicine-Family or General Practice | AGP |
| 086 | Pediatric Intensive Care | PIC |
| 087 | Neonatology | NE |
| 088 | Pediatrics | PD |
| 089 | Pediatric Allergy & Immunology | PAI |
| 306 | Pediatric Anesthesiology (Pediatrics) | PAN |
| 091 | Pediatric Pulmology Medicine | PDX |
| 198 | Pediatric Cardiothoracic Surgery | PCS |
| 092 | Pediatric Gastroenterology | PG |
| 093 | Pediatric Hematology-Oncology | PHO |
| 094 | Pediatric Diag Lab Immunology | PLI |
| 095 | Pediatric Nephrology | PNP |
| 192 | Pediatrics/Psychiatry/Child & Adolescent Ps | CPP |
| 096 | Pediatric Rheumatology | PPR |
| 097 | Sports Medicine - Pediatrics | PSM |
| 098 | Pediatric Cardiology | PDC |
| 099 | Preventive Medicine, Epidemiology or Public Health | EPI |
| 099 | Preventive Medicine, Epidemiology or Public Health | OE |
| 099 | Preventive Medicine, Epidemiology or Public Health | PH |
| 099 | Preventive Medicine, Epidemiology or Public Health | PHP |

A8. (Continued:)

| | | |
|---|---|---|
| 199 | Pharmaceutical Medicine | PHM |
| 100 | Physical Medicine & Rehabilitation | PM |
| 100 | Physical Medicine & Rehabilitation | IAR |
| 100 | Physical Medicine & Rehabilitation | PDR |
| 314 | Internal Medicine/Physical Medicine & Rehabilitation | MPM |
| 100 | Physical Medicine & Rehabilitation | RM |
| 200 | Physical Medicine & Rehabilitation (Pediatrics) | PMP |
| 101 | Hand Surgery-Plastic Surg | HSP |
| 102 | Plastic Surgery | OOP |
| 102 | Plastic Surgery | PLR |
| 103 | Anatomic Pathology | AP |
| 104 | Blood Banking-Transfusion Medicine | BBT |
| 104 | Blood Banking-Transfusion Medicine | LBM |
| 105 | Clinical Pathology | CLP |
| 106 | Dermatopathology | DPT |
| 107 | Hematology-Pathology | HEP |
| 108 | Medicine Microbiology | MMB |
| 109 | Neuropathology | NPT |
| 110 | Chemical Pathology | CP |
| 111 | Cytopathology | CY |
| 112 | Immunopathology | IPT |
| 113 | Pediatric Pathology | PP |
| 114 | Anatomic/Clinical Pathology | APL |
| 114 | Anatomic/Clinical Pathology | PTH |
| 115 | Radioisotopic Pathology | RIP |
| 307 | Public Health | PH |
| 196 | Internal Medicine/Preventive Medicine | IPM |
| 116 | Pulmonary Diseases | PUD |
| 116 | Pulmonary Diseases | PUL |
| 117 | Nuclear Radiology | NR |
| 118 | Pediatric Radiology | PRD |
| 119 | Radiology | DUS |
| 119 | Radiology | R |
| 119 | Radiology | RI |
| 119 | Radiology | RT |
| 119 | Radiology | RTD |
| 120 | Neuroradiology | NRA |
| 121 | Radiological Physics | RP |
| 122 | Angiography & Intervent'l Radiology | ANG |
| 122 | Angiography & Intervent'l Radiology | SCL |
| 123 | Radiation Oncology | RO |
| 123 | Radiation Oncology | TR |
| 124 | Cardiovascular or Thoracic Cardiovascular Surgery | CVS |
| 124 | Cardiovascular or Thoracic Cardiovascular Surgery | TS |

A8. (Continued:)

| | | |
|---|---|---|
| 125 | Urology | U |
| 125 | Urology | URS |
| 126 | Pediatric Urology | UP |
| 127 | Addictive Diseases | ADD |
| 128 | Critical Care-Medicine | CCM |
| 129 | Legal Medicine | LM |
| 130 | Clinical Pharmacology | PA |
| 131 | Unknown Blank | |
| 133 | Adolescent Medicine | ADL |
| 134 | Orthopedic Foot & Ankle Surg | OFA |
| 135 | Forensic Psychiatry | FPS |
| 136 | Hematology & Oncology | HEO |
| 137 | Internal Med-Pediatrics | IPD |
| 139 | Toxicology | TX |
| 142 | Psychosomatic Medicine | PYM |
| 145 | Pediatric Infectious Diseases | PID |
| 146 | Pediatric Ophthalmology | PO |
| 147 | Pulmonary-Critical Care | PUC |
| 153 | MOHS Micrographic Surgery | DMS |
| 154 | Hair Transplant | HT |
| 155 | Osteo Manipulative Treat +1 | OM1 |
| 156 | Osteopathic Manipulative Medicine | OMM |
| 157 | Sports Medicine - OMM | OMS |
| 158 | Osteo Manipulative Medicine | OMT |
| 159 | Proctology | PRO |
| 160 | Internship | IN |
| 161 | Retired | RET |
| 162 | Transitional Year | TY |
| 209 | Nuclear Cardiology | NC |
| 210 | Developmental & Behavioral Pediatrics | DBP |
| 159 | Proctology | PRO |
| 124 | Thoracic Surgery | TS |
| 410 | Clinical Neurophysiology | CN |
| 411 | Hematology/Oncology | HO |
| 413 | Nutrition | NTR |
| 414 | Pulmonary Critical Care Medicine | PCC |
| 415 | Pediatric Infectious Disease | PDI |
| 416 | Pediatric Nephrology | PN |
| 417 | Spinal Cord Injury Medicine | SCI |

997 Other (list) - **(USE VERY SPARINGLY; Thank and Terminate)**

998 (DK) **(Thank and Terminate)**
999 (Refused) **(Thank and Terminate)**

_____ _____
_____ (1066 - 1068)

**(If code 003, 005-007, 013-014, 018, 025, 028, 057, 099, 103-115, 117-122, 129-131, 135, 138-141, 148, 160-162, 209, 301-307, or 402 in A8, Continue; Otherwise, Skip to Note before A9)**

**READ:)** In this survey, we are only interviewing physicians in certain specialties, and your specialty is not among those being interviewed. So, it appears that we do not need any further information from you at this time, but we thank you for your cooperation. - **(Thank and Terminate)**

**(If code 201 in A8, Skip to A17; If code 042, 088, 137, or 195 in A8, Continue; If code 001-002, 004, 009, 012, 015-016, 020-022, 024, 035-041, 043-048, 055-056, 085, 116, 128, 136, 142, 143, 147, 149, 194, 196, 199, 308, 310, 313, 314, or 414 in A8, Skip to A9a; If code 017, 049-054, 063, 086-087, 089-094, 095-098, 133, 144-145, 192, 193, 200, 210, 409, 415, or 416 in A8, Skip to A9b; Otherwise, Skip to A15)**

A9. **(If code 042, 088, 137, or 195 in A8, ask:)** Do you spend more hours weekly in general **(response in A8)**, or a subspecialty in **(response in A8)**? **(INTERVIEWER NOTE: If respondent says 50/50 split, code as 1)**

**GENSUB**

1 General - **(Skip to A15)**

2 Subspecialty (including adolescent medicine or geriatrics) - **(Skip to A10)**

8 (DK) **(Skip to A15)**
9 (Refused) **(Skip to A15)** _____(1069)

A9a. **(If code 001-002, 004, 009, 012, 015-016, 020-022, 024, 035-041, 043-048, 055-056, 085, 116, 128, 136, 142, 143, 147, 149, 194, 196, 199, 308, 310, 313, 314, OR 414 in A8, ask:)** Do you spend most of your time practicing in **(response in A8)**, or in general internal medicine? **(INTERVIEWER NOTE: If respondent says 50/50 split, code as 1)**

**SIPNPED**

1 Subspecialty
2 General internal medicine (or general family practice)
3 General pediatrics

8 (DK)
9 (Refused) _____(2720)

**(All in A9a, Skip to A15)**

A9b. **(If code 017, 049-054, 063, 086-087, 089-098, 133, 144-145, 192, 193, 200, 210, 409, 415, or 416 in A8, ask:)** Do you spend most of your time practicing in **(response in A8)**, or in general pediatrics? **(INTERVIEWER NOTE: If respondent says 50/50 split, code as 1)**

**SIPPED**

1 Subspecialty
2 General internal medicine (General Family Practice)
3 General pediatrics

8 (DK)
9 (Refused) _____(1357)

**(All in A9b, Skip to A15)**

A10. **(If code 2 in A9, ask:)** And what is that subspecialty? **(If "More than one", say:)** We're interested in the one in which you spend the most hours weekly. (Open ended **and code from hard copy)** **(CHECK SPELLING)**

**SUBSPC**

**(If code 1 in S1 [MD-AMA LIST])**

| | | |
|---|---|---|
| 301 | Abdominal Radiology | (AR) |
| 202 | AIDS/HIV Specialist | |
| 001 | Allergy | (A) |
| 133 | Adolescent Medicine Pediatrics | (ADL) |
| 127 | Addiction Medicine | (ADM) |
| 132 | Addiction Psychiatry | (ADP) |
| 002 | Allergy & Immunology | (AI) |
| 003 | Allergy & Immunology/ Diagnostic Laboratory Immunology | (ALI) |
| 005 | Aerospace Medicine | (AM) |
| 085 | Adolescent Medicine (Internal Medicine) | (AMI) |
| 006 | Anesthesiology | (AN) |
| 007 | Pain Management | (APM) |
| 026 | Abdominal Surgery | (AS) |
| 103 | Anatomic Pathology | (ATP) |
| 104 | Bloodbanking/Transfusion Medicine | (BBK) |
| 190 | Cardiovascular Surgery | (CDS) |
| 008 | Critical Care Medicine (Anesthesiology) | (CCA) |
| 050 | Clinical Cytogenetics | (CCG) |
| 191 | Craniofacial Surgery | (CFS) |
| 128 | Critical Care Medicine (Internal Medicine) | (CCM) |
| 086 | Critical Care Pediatrics | (CCP) |
| 027 | Critical Care Surgery | (CCS) |
| 009 | Cardiovascular Disease | (CD) |
| 051 | Clinical Genetics | (CG) |
| 054 | Child Neurology | (CHN) |
| 010 | Child & Adolescent Psychiatry | (CHP) |
| 049 | Clinical Biochemical Genetics | (CCG) |
| 105 | Clinical Pathology | (CLP) |
| 052 | Clinical Molecular Genetics | (CMG) |
| 055 | Clinical Neurophysiology | (CN) |
| 011 | Colon & Rectal Surgery | (CRS) |
| 401 | Cosmetic Surgery | (CS) |
| 124 | Cardiothoracic Surgery | (CTS) |
| 012 | Dermatology | (D) |
| 164 | Dermatologic Surgery | (DS) |
| 013 | Clinical & Laboratory Dermatological Immunology | (DDL) |
| 035 | Diabetes | (DIA) |

A10. (Continued:)

| | | |
|---|---|---|
| 106 | Dermatopathology | (DMP) |
| 014 | Diagnostic Radiology | (DR) |
| 015 | Emergency Medicine | (EM) |
| 308 | Internal Medicine/Emergency Medicine | (MEM) |
| 036 | Endocrinology, Diabetes & Metabolism | (END) |
| 302 | Epidemiology | (EP) |
| 016 | Sports Medicine (Emergency Medicine) | (ESM) |
| 402 | Endovascular Surgical Neuroradiology | (ESN) |
| 140 | Medical Toxicology (Emergency Medicine) | (ETX) |
| 303 | Flex Residents | (FLX) |
| 403 | Family Medicine | (FM) |
| 018 | Forensic Pathology | (FOP) |
| 019 | Family Practice | (FP) |
| 020 | Geriatric Medicine (Family Practice) | (FPG) |
| 078 | Facial Plastic Surgery | (FPS) |
| 021 | Sports Medicine (Family Practice) | (FSM) |
| 022 | Gastroenterology | (GE) |
| 061 | Gynecological Oncology | (GO) |
| 023 | General Practice | (GP) |
| 024 | General Preventive Medicine | (GPM) |
| 029 | General Surgery | (GS) |
| 062 | Gynecology | (GYN) |
| 037 | Hematology | (HEM) |
| 038 | Hepatology | (HEP) |
| 107 | Hematology Pathology | (HMP) |
| 030 | Head & Neck Surgery | (HNS) |
| 136 | Hematology/Oncology | (HO) |
| 070 | Hand Surgery Orthopedics | (HSO) |
| 101 | Hand Surgery Plastic | (HSP) |
| 031 | Hand Surgery | (HSS) |
| 201 | Hospitalists | (HOS) |
| 039 | Clinical Cardiac Electrophysiology | (ICE) |
| 040 | Infectious Diseases | (ID) |
| 004 | Immunology | (IG) |
| 041 | Clinical & Laboratory Immunology (IM) | (ILI) |
| 042 | Internal Medicine | (IM) |
| 194 | Interventional Cardiology | (IC) |
| 043 | Geriatric Medicine (IM) | (IMG) |
| 044 | Sports Medicine | (ISM) |
| 309 | Sports Medicine (Physical Medicine and Rehabilitation) (IM) | (PMM) |
| 129 | Legal Medicine | (LM) |
| 138 | Medical Management | (MDM) |
| 063 | Maternal & Fetal Medicine | (MFM) |
| 304 | Maxillofacial Radiology | (MXR) |
| 053 | Medical Genetics | (MG) |
| 108 | Medical Microbiology | (MM) |
| 195 | Internal Medicine/Family Practice | (IFP) |

A10. (Continued:)

| | | |
|---|---|---|
| 137 | Internal Medicine/Pediatrics | (MPD) |
| 099 | Public Health & General Preventive Medicine | (MPH) |
| 056 | Neurology | (N) |
| 310 | Internal Medicine/Neurology | (MN) |
| 311 | Neurology/Physical Medicine and Rehabilitation | (NPR) |
| 058 | Critical Care Medicine (Neurosurgery) | (NCC) |
| 404 | Neurodevelopmental Disability | (NDN) |
| 045 | Nephrology | (NEP) |
| 057 | Nuclear Medicine | (NM) |
| 109 | Neuropathology | (NP) |
| 087 | Neonatal/Perinatal Medicine | (NPM) |
| 117 | Nuclear Radiology | (NR) |
| 305 | Neurology/Diagnostic Radiology/ Neuroradiology | (NRN) |
| 059 | Neurological Surgery | (NS) |
| 060 | Pediatric Neurosurgery | (NSP) |
| 046 | Nutrition | (NTR) |
| 405 | Neuropsychiatry | (NUP) |
| 071 | Adult Reconstructive Orthopedics | (OAR) |
| 064 | Obstetrics & Gynecology | (OBG) |
| 065 | Obstetrics | (OBS) |
| 066 | OB Critical Care Medicine | (OCC) |
| 134 | Foot & Ankle Orthopedics | (OFA) |
| 068 | Occupational Medicine | (OM) |
| 406 | Oral and Maxillofacial Surgery | (OMF) |
| 072 | Musculoskeletal Oncology | (OMO) |
| 047 | Medical Oncology | (ON) |
| 073 | Pediatric Orthopedics | (OP) |
| 069 | Ophthalmology | (OPH) |
| 074 | Orthopedic Surgery | (ORS) |
| 028 | Other Specialty | (OS) |
| 075 | Sports Medicine (Orthopedic Surgery) | (OSM) |
| 076 | Orthopedic Surgery of the Spine | (OSS) |
| 079 | Otology | (OT) |
| 197 | Otology/Neurotology | (NO) |
| 080 | Otolaryngology | (OTO) |
| 077 | Orthopedic Trauma | (OTR) |
| 082 | Psychiatry | (P) |
| 312 | Psychiatry/Family Practice | (FPP) |
| 313 | Internal Medicine/Psychiatry | (MP) |
| 130 | Clinical Pharmacology | (PA) |
| 147 | Pulmonary Critical Care Medicine | (PCC) |
| 110 | Chemical Pathology | (PCH) |
| 111 | Cytopathology | (PCP) |
| 088 | Pediatrics | (PD) |
| 089 | Pediatric Allergy | (PDA) |
| 306 | Pediatric Anesthesiology (Pediatrics) | (PAN) |
| 098 | Pediatric Cardiology | (PDC) |

A10. (Continued:)

| | | |
|---|---|---|
| 198 | Pediatric Cardiothoracic Surgery | (PCS) |
| 193 | Pediatric Emergency Medicine | (EMP) |
| 090 | Pediatric Endocrinology | (PDE) |
| 145 | Pediatric Infectious Diseases | (PDI) |
| 081 | Pediatric Otolaryngology | (PDO) |
| 091 | Pediatric Pulmonology | (PDP) |
| 192 | Pediatrics/Psychiatry/Child & Adolescent Ps | (CPP) |
| 118 | Pediatric Radiology | (PDR) |
| 032 | Pediatric Surgery | (PDS) |
| 139 | Medical Toxicology (Pediatrics) | (PDT) |
| 144 | Pediatric Emergency Medicine | (PE) |
| 017 | Pediatric Emergency Medicine (Pediatrics) | (PEM) |
| 135 | Forensic Psychiatry | (PFP) |
| 092 | Pediatric Gastroenterology | (PG) |
| 093 | Pediatric Hematology/Oncology | (PHO) |
| 112 | Immunopathology | (PIP) |
| 094 | Clinical & Laboratory Immunology (Pediatrics) | (PLI) |
| 143 | Palliative Medicine | (PLM) |
| 100 | Physical Medicine & Rehab | (PM) |
| 314 | Internal Medicine/Physical Medicine & Rehabilitation | (MPM) |
| 200 | Physical Medicine & Rehabilitation (Pediatrics) | (PMP) |
| 142 | Pain Medicine | (PMD) |
| 407 | Sports Medicine (Physical Medicine and Rehabilitation) | (PMM) |
| 095 | Pediatric Nephrology | (PN) |
| 146 | Pediatric Opthalmology | (PO) |
| 113 | Pediatric Pathology | (PP) |
| 096 | Pediatric Rheumatology | (PPR) |
| 102 | Plastic Surgery/Cosmetic Surgery | (PS) |
| 199 | Pharmaceutical Medicine | (PHM) |
| 307 | Public Health | (PH) |
| 408 | Plastic Surgery within the Head and Neck | (PSH) |
| 097 | Sports Medicine (Pediatrics) | (PSM) |
| 114 | Anatomic/Clinical Pathology | (PTH) |
| 141 | Medical Toxicology (Preventive Medicine) | (PTX) |
| 116 | Pulmonary Diseases | (PUD) |
| 196 | Internal Medicine/Preventive Medicine | (IPM) |
| 083 | Psychoanalysis | (PYA) |
| 084 | Geriatric Psychiatry | (PYG) |
| 119 | Radiology | (R) |
| 067 | Reproductive Endocrinology | (REN) |
| 048 | Rheumatology | (RHU) |
| 115 | Radioisotopic Pathology | (RIP) |
| 120 | Neuroradiology | (RNR) |

A10. (Continued:)

| | | |
|---|---|---|
| 123 | Radiation Oncology | (RO) |
| 121 | Radiological Physics | (RP) |
| 409 | Pediatric Rehabilitation | (RPM) |
| 150 | Spinal Cord Injury | (SCI) |
| 149 | Sleep Medicine | (SM) |
| 151 | Surgical Oncology | (SO) |
| 148 | Selective Pathology | (SP) |
| 033 | Trauma Surgery | (TRS) |
| 152 | Transplant Surgery | (TTS) |
| 125 | Urology | (U) |
| 025 | Undersea Medicine | (UM) |
| 126 | Pediatric Urology | (UP) |
| 131 | Unspecified | (US) |
| 122 | Vascular & Interventional Radiology | (VIR) |
| 165 | Vascular Medicine | (VM) |
| 034 | Vascular Surgery | (VS) |
| 210 | Developmental & Behavioral Pediatrics | (DBP) |
| 159 | Proctology | (PRO) |
| 124 | Thoracic Surgery | (TS) |

997 Other (list) - **(USE VERY SPARINGLY; Thank and Terminate)**

998 (DK) **(Thank and Terminate)**
999 (Refused) **(Thank and Terminate)**

_____ _____
_____ (1070 - 1072)

**(If code 2 in S1 [DO-AOA LIST])**

| | | |
|---|---|---|
| 301 | Abdominal Radiology | AR |
| 202 | AIDS/HIV Specialist | |
| 002 | Allergy and Immunology | AI |
| 003 | Allergy-Diagnostic Lab Immunology | ALI |
| 004 | Immunology | IG |
| 005 | Preventive Medicine-Aerospace Medicine | AM |
| 006 | Anesthesiology | AN |
| 006 | Anesthesiology | CAN |
| 006 | Anesthesiology | IRA |
| 006 | Anesthesiology | OBA |
| 006 | Anesthesiology | PAN |
| 007 | Pain Management | APM |
| 007 | Pain Management | PMR |
| 008 | Critical Care-Anesthesiology | CCA |
| 009 | Cardiovascular Diseases-Cardiology | C |
| 009 | Cardiovascular Diseases-Cardiology | CVD |
| 009 | Cardiovascular Diseases-Cardiology | IC |
| 190 | Cardiovascular Surgery | CDS |
| 191 | Craniofacial Surgery | CFS |

A10. (Continued:)

| | | |
|---|---|---|
| 010 | Pediatric Psychiatry | CHP |
| 010 | Pediatric Psychiatry | PDP |
| 011 | Colon & Rectal Surgery | CRS |
| 012 | Dermatology | D |
| 015 | Emergency Medicine | EM |
| 014 | Diagnostic Radiology | DR |
| 308 | Internal Medicine/Emergency Medicine | MEM |
| 015 | Emergency Medicine | EMS |
| 015 | Emergency Medicine | FEM |
| 015 | Emergency Medicine | IEM |
| 302 | Epidemiology | EP |
| 016 | Sports Medicine (Emergency Medicine) | ESM |
| 017 | Pediatric Emergency Medicine | PEM |
| 303 | Flex Residents | FLX |
| 018 | Forensic Pathology | FOP |
| 019 | Family Practice | FP |
| 019 | Family Practice | UFP |
| 020 | Geriatrics-General or Family Practice | GFP |
| 020 | Geriatrics-General or Family Practice | GGP |
| 021 | Sports Medicine-Family or General Practice | SFP |
| 021 | Sports Medicine-Family or General Practice | SGP |
| 022 | Gastroenterology | GE |
| 023 | General Practice | GP |
| 024 | Preventive Medicine | PVM |
| 025 | Undersea Medicine | UM |
| 026 | Abdominal Surgery | AS |
| 027 | Critical Care-Surgery or Trauma | CCS |
| 027 | Critical Care-Surgery or Trauma | CCT |
| 028 | Other Specialty | OS |
| 029 | Surgery-General | S |
| 030 | Head & Neck Surgery | HNS |
| 031 | Hand Surgery | HS |
| 031 | Hand Surgery | HSS |
| 201 | Hospitalists | |
| 032 | Pediatric Surgery | PDS |
| 033 | Traumatic Surgery | TRS |
| 034 | Vascular Surgery-General or Peripheral | GVS |
| 034 | Vascular Surgery-General or Peripheral | PVS |
| 036 | Endocrinology | END |
| 037 | Hematology | HEM |
| 039 | Cardiac Electrophysiology | ICE |
| 040 | Infectious Diseases | ID |
| 041 | Diag Lab Immunology-Int Med | ILI |
| 042 | Internal Medicine | IM |
| 194 | Interventional Cardiology | IC |
| 195 | Internal Medicine/Family Practice | IFP |

A10. (Continued:)

| | | |
|---|---|---|
| 042 | Internal Medicine | IP |
| 043 | Geriatrics-Internal Medicine | GER |
| 309 | Geriatrics-Internal Medicine | GIM |
| 044 | Sports Medicine (Physical Medicine & Rehabilitation) | PMM |
| 044 | Sports Medicine | ISM |
| 044 | Sports Medicine | PMS |
| 044 | Sports Medicine | RMS |
| 044 | Sports Medicine | SM |
| 045 | Nephrology | NEP |
| 046 | Nutrition | NTR |
| 047 | Oncology | ON |
| 048 | Rheumatology | RHU |
| 050 | Clinical Cytogenetics | CCG |
| 051 | Clinical Genetics | CG |
| 053 | Medical Genetics | IMG |
| 054 | Pediatric or Child Neurology | CHN |
| 054 | Pediatric or Child Neurology | PDN |
| 055 | Clinical Neurophysiology | CN |
| 056 | Neurology | N |
| 310 | Internal Medicine/Neurology | MN |
| 311 | Neurology/Physical Medicine & Rehab | NPR |
| 056 | Neurology | NMD |
| 056 | Neurology | NP |
| 056 | Neurology | NPN |
| 305 | Neurology/Diagnostic Radiology/ Neuroradiology | NRN |
| 057 | Nuclear Medicine | NI |
| 057 | Nuclear Medicine | NM |
| 057 | Nuclear Medicine | NV |
| 058 | Critical Care-Neuro Surgery | NCC |
| 059 | Neurological Surgery | NS |
| 061 | Gynecological Oncology | GO |
| 062 | Gynecology | GS |
| 062 | Gynecology | GYN |
| 063 | Maternal & Fetal Medicine | MFM |
| 304 | Maxillofacial Radiology | MXR |
| 064 | Obstetrics & Gynecology | OBG |
| 064 | Obstetrics & Gynecology | OGS |
| 065 | Obstetrics | OBS |
| 066 | Critical Care-Obstetrics & Gynecology | OCC |
| 067 | Reproductive Endocrinology | RE |
| 068 | Occupational Medicine | OCM |
| 068 | Occupational Medicine | OM |

A10. (Continued:)

| | | |
|---|---|---|
| 069 | Ophthalmology | COR |
| 069 | Ophthalmology | OAS |
| 069 | Ophthalmology | OCR |
| 069 | Ophthalmology | OGL |
| 069 | Ophthalmology | OPH |
| 069 | Ophthalmology | VRS |
| 070 | Hand Surgery-Orthopedic Surg | HSO |
| 071 | Adult Reconstructive Orthopedics | OAR |
| 072 | Musculoskeletal Oncology | OMO |
| 073 | Pediatric Orthopedics | OP |
| 074 | Orthopedic Surgery | AJI |
| 074 | Orthopedic Surgery | OR |
| 074 | Orthopedic Surgery | ORS |
| 075 | Sports Medicine-Orthopedic Surgery | OSM |
| 076 | Orthopedic Surgery-Spine | OSS |
| 078 | Facial Plastic Surgery | OPL |
| 080 | Otolaryngology or Rhinology | OTL |
| 080 | Otolaryngology or Rhinology | OTR |
| 080 | Otolaryngology or Rhinology | RHI |
| 197 | Otology/Neurotology | NO |
| 081 | Pediatric Otolaryngology | PDO |
| 082 | Psychiatry | P |
| 312 | Psychiatry/Family Practice | FPP |
| 313 | Psychiatry/Internal Medicine | MP |
| 083 | Psychoanalysis | PYA |
| 084 | Geriatric Psychiatry | PYG |
| 085 | Adolescent Medicine-Family or General Practice | AFP |
| 085 | Adolescent Medicine-Family or General Practice | AGP |
| 086 | Pediatric Intensive Care | PIC |
| 087 | Neonatology | NE |
| 088 | Pediatrics | PD |
| 089 | Pediatric Allergy & Immunology | PAI |
| 306 | Pediatric Anesthesiology (Pediatrics) | PAN |
| 091 | Pediatric Pulmology Medicine | PDX |
| 198 | Pediatric Cardiothoracic Surgery | PCS |
| 092 | Pediatric Gastroenterology | PG |
| 093 | Pediatric Hematology-Oncology | PHO |
| 094 | Pediatric Diag Lab Immunology | PLI |
| 095 | Pediatric Nephrology | PNP |
| 192 | Pediatrics/Psychiatry/Child & Adolescent Ps | CPP |
| 096 | Pediatric Rheumatology | PPR |
| 097 | Sports Medicine - Pediatrics | PSM |
| 098 | Pediatric Cardiology | PDC |

A10. (Continued:)

| | | |
|---|---|---|
| 099 | Preventive Medicine, Epidemiology or Public Health | EPI |
| 099 | Preventive Medicine, Epidemiology or Public Health | OE |
| 099 | Preventive Medicine, Epidemiology or Public Health | PH |
| 099 | Preventive Medicine, Epidemiology or Public Health | PHP |
| 199 | Pharmaceutical Medicine | PHM |
| 100 | Physical Medicine & Rehabilitation | PM |
| 100 | Physical Medicine & Rehabilitation | IAR |
| 100 | Physical Medicine & Rehabilitation | PDR |
| 314 | Internal Medicine/Physical Medicine & Rehabilitation | MPM |
| 100 | Physical Medicine & Rehabilitation | RM |
| 200 | Physical Medicine & Rehabilitation (Pediatrics) | PMP |
| 101 | Hand Surgery-Plastic Surg | HSP |
| 102 | Plastic Surgery | OOP |
| 102 | Plastic Surgery | PLR |
| 103 | Anatomic Pathology | AP |
| 104 | Blood Banking-Transfusion Medicine | BBT |
| 104 | Blood Banking-Transfusion Medicine | LBM |
| 105 | Clinical Pathology | CLP |
| 106 | Dermatopathology | DPT |
| 107 | Hematology-Pathology | HEP |
| 108 | Medicine Microbiology | MMB |
| 109 | Neuropathology | NPT |
| 110 | Chemical Pathology | CP |
| 111 | Cytopathology | CY |
| 112 | Immunopathology | IPT |
| 113 | Pediatric Pathology | PP |
| 114 | Anatomic/Clinical Pathology | APL |
| 114 | Anatomic/Clinical Pathology | PTH |
| 115 | Radioisotopic Pathology | RIP |
| 307 | Public Health | PH |
| 196 | Internal Medicine/Preventive Medicine | IPM |
| 116 | Pulmonary Diseases | PUD |
| 116 | Pulmonary Diseases | PUL |
| 117 | Nuclear Radiology | NR |
| 118 | Pediatric Radiology | PRD |
| 119 | Radiology | DUS |
| 119 | Radiology | R |
| 119 | Radiology | RI |
| 119 | Radiology | RT |
| 119 | Radiology | RTD |
| 120 | Neuroradiology | NRA |

A10. (Continued:)

| | | |
|---|---|---|
| 121 | Radiological Physics | RP |
| 122 | Angiography & Intervent'l Radiology | ANG |
| 122 | Angiography & Intervent'l Radiology | SCL |
| 123 | Radiation Oncology | RO |
| 123 | Radiation Oncology | TR |
| 124 | Cardiovascular or Thoracic Cardiovascular Surgery | CVS |
| 124 | Cardiovascular or Thoracic Cardiovascular Surgery | TS |
| 125 | Urology | U |
| 125 | Urology | URS |
| 126 | Pediatric Urology | UP |
| 127 | Addictive Diseases | ADD |
| 128 | Critical Care-Medicine | CCM |
| 129 | Legal Medicine | LM |
| 130 | Clinical Pharmacology | PA |
| 131 | Unknown Blank | |
| 133 | Adolescent Medicine | ADL |
| 134 | Orthopedic Foot & Ankle Surg | OFA |
| 135 | Forensic Psychiatry | FPS |
| 136 | Hematology & Oncology | HEO |
| 137 | Internal Med-Pediatrics | IPD |
| 139 | Toxicology | TX |
| 142 | Psychosomatic Medicine | PYM |
| 145 | Pediatric Infectious Diseases | PID |
| 146 | Pediatric Ophthalmology | PO |
| 147 | Pulmonary-Critical Care | PUC |
| 153 | MOHS Micrographic Surgery | DMS |
| 154 | Hair Transplant | HT |
| 155 | Osteo Manipulative Treat +1 | OM1 |
| 156 | Osteopathic Manipulative Medicine | OMM |
| 157 | Sports Medicine - OMM | OMS |
| 158 | Osteo Manipulative Medicine | OMT |
| 159 | Proctology | PRO |
| 160 | Internship | IN |
| 161 | Retired | RET |
| 162 | Transitional Year | TY |
| 209 | Nuclear Cardiology | NC |
| 210 | Developmental & Behavioral Pediatrics | DBP |
| 159 | Proctology | PRO |
| 124 | Thoracic Surgery | TS |
| 410 | Clinical Neurophysiology | CN |
| 411 | Hematology/Oncology | HO |
| 413 | Nutrition | NTR |
| 414 | Pulmonary Critical Care Medicine | PCC |
| 415 | Pediatric Infectious Disease | PDI |
| 416 | Pediatric Nephrology | PN |
| 417 | Spinal Cord Injury Medicine | SCI |

A10. (Continued:)

997 Other (list) - **(USE VERY SPARINGLY; Thank and Terminate)**

998 (DK) **(Thank and Terminate)**
999 (Refused) **(Thank and Terminate)**

_____ _____
_____ (1070 - 1072)

**(If code 003, 005-007, 013-014, 018, 025, 028, 057, 099, 103-115, 117-122, 129-131, 135, 138-141, 148, 160-162, 209, 301-307, or 402 in A10, Continue; Otherwise, Skip to Note before A11)**

**(READ:)** In this survey, we are only interviewing physicians in certain specialties, and your specialty is not among those being interviewed. So, it appears that we do not need any further information from you at this time, but we thank you for your cooperation. - **(Thank and Terminate)**

**(If code 201 in A10, Skip to A17; Otherwise, Continue)**

A11. Are you board-certified in **(response in A10)**?
BDCTSB

1 Yes
2 No
8 (DK)
9 (Refused) _____(1358)

**(Question A12 deleted)** HOLD _____(1630)

A13. Are you board-certified in **(response in A8)**?
BDCTSP

1 Yes
2 No
8 (DK)
9 (Refused) _____(1631)

**(If code 2, 8, or 9 in A11 AND A13, Skip to A17; Otherwise, Skip to A19)**

**(Question A14 deleted)** HOLD _____(1633)

A15. Are you board-certified in **(response in A8)**?
**(INTERVIEWER NOTE: If physician says "Board-Certified in Internal Medicine" or "Board-Certified in Pediatrics", code as 1)**

**BDCTPSP**

1 Yes
2 No
8 (DK)
9 (Refused) _____(1634)

**(If code 1 in A15, Skip to A19; Otherwise, Continue)**

**(Question A16 deleted)** HOLD _____(1636)

A17. Are you board certified in any specialty?

**BDCTAY**

1 Yes
2 No
8 (DK)
9 (Refused) _____(1078)

**(Question A18 deleted)** HOLD _____(1079)

A19. Many of the remaining questions are about your practice and your relationships with patients. Before we begin those questions, let me ask you: Thinking very generally about your satisfaction with your overall career in medicine, would you say that you are CURRENTLY **(read 5-1)**?

**CARSAT**

5 Very satisfied
4 Somewhat satisfied
3 Somewhat dissatisfied
2 Very dissatisfied, OR
1 Neither satisfied nor dissatisfied

8 (DK)
9 (Refused) _____(1080)

CLOCK:

_____ _____
_____ (1545 - 1548)

# ***SECTION B***
# *UTILIZATION OF TIME; PRODUCTIVITY; INFORMATION BROUGHT BY PATIENTS; CASE MIX*

**TIME AND PRODUCTIVITY**

B1. Approximately how many weeks did you practice medicine during 2003? Exclude time missed due to vacation, illness, and other absences. **(If necessary, say:)** Exclude family leave, military service, and professional conferences. If your office is closed for several weeks of the year, those weeks should NOT be counted as weeks worked. **(INTERVIEWER NOTE: Response refers to all practices, not just main practice)** (Open ended **and code actual number)**

**WKSWRK**

53-
97 (BLOCK)

DK (DK)
RF (Refused)

_____ _____
_____ (1081) (1082)

B2. During your last complete week of work, approximately how many hours did you spend in all medically-related activities? Please include all time spent in administrative tasks, professional activities, and direct patient care. Exclude time on call when not actually working. **(INTERVIEWER NOTE: If necessary, read:)** Direct patient care includes time spent on patient record keeping, patient-related office work, and travel time connected with seeing patients. (Open ended **and code actual number)** **(INTERVIEWER NOTE: Response refers to all practices, not just main practice)**

**HRSMD A**

169-
997 (BLOCK)

DK (DK)
RF (Refused)

_____ _____
_____ (1083 - 1085)

[Deleted Note]

B3. **(If code 001-168 in B2, ask:)** Of these **(response in B2)** hours, how many did you spend in direct patient care activities? Direct care of patients includes face-to-face contact with patients, as well as patient record keeping and office work, travel time connected with seeing patients, and communication with other physicians, hospitals, pharmacies, and other places on a patient's behalf. **(INTERVIEWER NOTE:)** **(If necessary, say:)** INCLUDE time spent on patient record keeping, patient-related office work, and travel time connected with seeing patients. EXCLUDE time spent in training, teaching, or research, any hours on-call when not actually working, and travel between home and work at the beginning and end of the work day. **(If appropriate, say:)** INCLUDE ALL PRACTICES, not just the main practice. (Open ended **and code actual number)**

**(If code DK or RF in B2, ask:)** About how many hours did you spend in direct patient care activities? **(If necessary, say:)** EXCLUDE time spent in training, teaching, or research, any hours on-call when not actually working, and travel between home and work at the beginning and end of the work day. **(If appropriate, say:)** INCLUDE ALL PRACTICES, not just the main practice. (Open ended **and code actual number)**

**HRSPT A**

169-
997 (BLOCK)

DK (DK) **(Skip to Note after B5)**
RF (Refused) **(Skip to Note after B5)**

_____ _____
_____ (1086 - 1088)

**(If response in B3 = response in B2, Continue;**
**If response in B3 > response in B2, Skip to B4;**
**Otherwise, Skip to Note after B5)**

B3a. So, you spent all of your time working in direct patient care activities, is that right?

**ALLPAT**

1 Yes - **(Skip to Note after B5)**

2 No - **(Continue)**

8 (DK) **(Skip to Note after B5)**
9 (Refused) **(Skip to Note after B5)** _____(1115)

B3b. **(If code 2 in B3a, ask:)** I have recorded that you spent **(response in B2)** hours in all medically related activities and **(response in B3)** hours in direct patient care. Which of these is incorrect?

**MEDPAT**

1 All medically related activities hours - **(Continue)**

2 Direct patient care hours - **(Skip to B3d)**

3 (Neither are correct) - **(Continue)**

4 (Both are correct) **(Skip to Note after B5)**
8 (DK) **(Skip to Note after B5)**
9 (Refused) **(Skip to Note after B5)** _____(1116)

B3c. **(If code 1 or 3 in B3b, ask:)** Thinking of your last complete week of work, approximately how many hours did you spend in all medically related activities? Please include all time spent in administrative tasks, professional activities, and direct patient care. Exclude time on call when not actually working. (Open ended **and code actual number)**

**HRSMD B**

169-
997 (BLOCK)

DK (DK)
RF (Refused)

_____ _____
_____ (1117 - 1119)

**(If code 1 in B3b, Skip to Note after B5; Otherwise, Continue)**

B3d. **(If code 2 or 3 in B3b, ask:)** Thinking of your last complete week of work, about how many hours did you spend in direct patient care activities? **(If necessary, say:)** INCLUDE time spent on patient record-keeping, patient-related office work, and travel time connected with seeing patients. EXCLUDE time spent in training, teaching, or research, any hours on-call when not actually working, and travel between home and work at the beginning and end of the work day. **(If appropriate, say:)** INCLUDE ALL PRACTICES, not just the main practice. (Open ended **and code actual number)**

**HRSPT B**

169-
997 (BLOCK)

DK (DK)
RF (Refused)

_____ _____
_____ (1194 - 1196)

**(All in B3d, Skip to Note after B5)**

B4. I may have made a recording mistake. My computer is showing that I've recorded more hours spent in direct patient care than in ALL medical activities. So, during your last complete week of work, approximately how many hours did you spend in ALL medically related activities? Please include all time spent in administrative tasks, professional activities, and direct patient care, as well as any hours spent on call when actually working? (Open ended **and code actual number)**

**HRSMD C**

169-
997 (BLOCK)

DK (DK)
RF (Refused)

_____ _____
_____ (1089 - 1091)

B5. And of those total [**(response in B4)**] hours, about how many did you spend in direct patient care activities? **(If necessary, say:)** INCLUDE time spent on patient record-keeping, patient-related office work, and travel time connected with seeing patients. EXCLUDE time spent in training, teaching, or research, any hours on-call when not actually working, and travel between home and work at the beginning and end of the work day. **(If appropriate, say:)** INCLUDE ALL PRACTICES, not just the main practice. (Open ended **and code actual number)**

**HRSPT C**

169-
997 (BLOCK)

DK (DK)
RF (Refused)

_____ _____
_____ (1092 - 1094)

**(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8**
**OR If code 1, 8, or 9 in A9 OR**
**If code 042, 088, or 137 in A10 OR**
**If code 2 or 3 in A9a OR**
**If code 2 or 3 in A9b, Continue;**
**Otherwise, Skip to B6)**

**(Deleted CLOCK)** HOLD _____(3557-3560)

B5a. Again, thinking of your last complete week of work, how many patient visits did you personally have in each of the following settings? Please count as one visit each time you saw a patient. How about **(read and rotate A-D)**? (Open ended **and code actual number)** **(INTERVIEWER NOTE: The categories in this question are mutually exclusive. If a respondent works in an outpatient clinic but is asked the "in the office" item first and gives a number, code the number given for "in the office" into the "outpatient clinic" item and recode the response to "office" to 0)** **(SURVENT NOTE: Allow interviewers to verify responses over 400 in any category. In this instance, interviewer say:)** That's **(response in A-D, as appropriate)**, right? **(If respondent wants to change their response, allow interviewer to enter the new number in place of the old number.)**

000 None
997 997+
998 (DK)
999 (Refused)

**OFFICEV**

A. In the office

_____ _____
_____ (3401 - 3403)

**OUTPTV**

B. In outpatient clinics

_____ _____
_____ (3404 - 3406)

**NURSHMV**

C. In nursing homes and other extended care facilities

_____ _____
_____ (3407 - 3409)

**HOSPV**

D. On hospital rounds

_____ _____
_____ (3410 - 3412)

**(Deleted CLOCK)** HOLD _____(3413-3416)

B6. During the LAST MONTH, how many hours, if any, did you spend providing CHARITY care? By this we mean, that because of the financial need of the patient you charged either no fee or a reduced fee. Please do not include time spent providing services for which you expected, but did not receive, payment. **(Probe:)** Your best estimate would be fine. (Open ended **and code actual number)**

**(If necessary, say:)** EXCLUDE bad debt and time spent providing services under a discounted fee for service contract or seeing Medicare and [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCAL patients/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access") patients/**(Otherwise, read:)** Medicaid patients]. **(If necessary, read:)** By the LAST MONTH, we mean the last 4 weeks.

**HRFREE**

000 None
DK (DK)
RF (Refused)

_____ _____
_____ (2544 - 2546)

**(If code 000 in B6, Skip to B12; Otherwise, Continue)**

B6a. Where do you typically provide charity care, **(read and rotate 1-3, then 4)**? **(INTERVIEWER NOTE: If respondent provides charity care in more than one place, ask for the one where they provide care most often.)**

**LOCFREE**

1 In your main practice
2 On-call at a hospital emergency department
3 In another practice or clinic
4 Or somewhere else

8 (DK)
9 (Refused) _____(3417)

**(Questions B7-B11 deleted)** HOLD _____(3207-3212)

HOLD _____(3256-3258)

HOLD _____(3418-3421)

HOLD _____(3215-3216)

**CASE MIX**

**(Deleted CLOCK)** HOLD _____(3422-3425)

B12. About what percentage of your patients has a chronic medical condition? **(Probe:)** Your best estimate is fine. (Open ended **and code actual percent)**

**CHRNPT**

000 None
101 Less than 1%
102 (DK)
103 (Refused)

_____ _____
_____ (3426 - 3428)

[Deleted Note]

**(Question B13 deleted)** HOLD _____(3429-3431)

B14. About what percentage of your patients are **(read and rotate A-C)**? **(Probe:)** Your best estimate is fine. (Open ended **and code actual percent)**

000 None
101 Less than 1%
102 (DK)
103 (Refused)

**BLCKPT**

A. African-American or Black

_____ _____
_____ (3432 - 3434)

**HISPPT**

B. Hispanic or Latino

_____ _____
_____ (3435 - 3437)

**ASIAPT**

C. Asian or Pacific Islander

_____ _____
_____ (3438 - 3440)

B15. About what percentage of your patients do you have a hard time speaking with or understanding because you speak different languages? **(Probe:)** Your best estimate is fine. (Open ended **and code actual percent)**

**LANGPT**

000 None
101 Less than 1%
102 (DK)
103 (Refused)

_____ _____
_____ (3441 - 3443)

CLOCK:

_____ _____
_____ (2184 - 2187)

## *SECTION C*
## *TYPE AND SIZE OF PRACTICE*

**(Question CA deleted)**

**(READ:)** Now, I would like to ask you a series of questions about the main practice in which you work.

C1. Are you a full owner, a part owner, or not an owner of this practice? **(INTERVIEWER NOTE: A shareholder of the practice in which they work should be coded as 2 - Part owner)**

**OWNPR**

| | | |
|---|---|---|
| 1 | Full owner | **(Continue)** |
| 2 | Part owner | **(Continue)** |
| 3 | Not an owner | **(Skip to C3)** |
| 8 | (DK) | **(Skip to C3)** |
| 9 | (Refused) | **(Skip to C3)** |

_____(1104)

C2. **(If code 1 or 2 in C1, ask:)** Which of the following best describes this practice? Is it **(read 06-16, then 01)**? **(INTERVIEWER NOTE: A free-standing clinic includes non-hospital-based ambulatory care, surgical, and emergency care centers)**

**TOPOWN**

| | |
|---|---|
| 01 | OR, something else (list) |
| 02-05 | HOLD |
| 06 | A practice owned by one physician (solo practice) |
| 07 | A two physician-owned practice |
| 08 | A group practice of three or more physicians (see AMA definition on card) |
| 09 | A group model HMO |
| 10 | A staff model HMO |
| 11-15 | HOLD |
| 16 | A free-standing clinic |
| 98 | (DK) |
| 99 | (Refused) |

_____ _____
(1105) (1106)

_____

**(If code 08 or 16 in C2, Continue; Otherwise, Skip to C7)**

C2a. Is the practice a single-specialty or multi-specialty practice?

**OWNNSPC**

1 Single-specialty - **(Skip to C7)**

2 Multi-specialty - **(Continue)**

8 (DK) **(Skip to C7)**
9 (Refused) **(Skip to C7)** _____(1637)

**(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, Skip to C2c; Otherwise, Continue)**

C2b. Are any of the physicians in the practice in primary care specialties? **(Probe:)** By primary care specialties, we mean general or family practice, general pediatrics, or general internal medicine.

**OWNPCP**

1 Yes
2 No
8 (DK)
9 (Refused) _____(1638)

**(All in C2b, Skip to C7)**

C2c. **(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, ask:)** Are any of the physicians in the practice in specialties other than general or family practice, general pediatrics or general internal medicine?

**OWNSPEC**

1 Yes
2 No
8 (DK)
9 (Refused) _____(1639)

**(All in C2c, Skip to C7)**

C3. **(If code 3, 8, or 9 in C1, ask:)** Which of the following best describes your current employer or employment arrangement? Are you employed by **(read 06-16, then 01)**? **(INTERVIEWER NOTE: Stop once response is given)** **(If necessary, say:)** An EMPLOYER is the entity that pays you and should not be confused with where you work. For instance, your employer could be a group practice even if you work in a hospital.

**TOPEMP**

01 OR, something else (do NOT list here) - **(Skip to C3b)**

02-05 HOLD

06 A practice owned by one physician (solo practice) - **(Skip to C7)**

07 A two physician-owned practice - **(Skip to C7)**

08 A group practice of three or more physicians (see) AMA definition on card) - **(Continue)**

09 A group model HMO **(Skip to C7)**
10 A staff model HMO **(Skip to C7)**

12 A medical school or university **(Skip to C6b)**
13 A non-government hospital or group of hospitals **(Skip to C6b)**

14 City, county or state government - **(Skip to C3a)**

16 A free-standing clinic - **(Continue)**

98 (DK) **(Skip to C3b)**
99 (Refused) **(Skip to C3b)**

_____ _____
(1107) (1108)

C3aa. **(If code 08 or 16 in C3, ask:)** Is the practice a single-specialty or multi-specialty practice?

**EMPNSPC**

1 Single-specialty - **(Skip to C7)**

2 Multi-specialty - **(Continue)**

8 (DK) **(Skip to C7)**
9 (Refused) **(Skip to C7)** _____(1640)

**(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, Skip to C3ac; Otherwise, Continue)**

C3ab. Are any of the physicians in the practice in primary care specialties? **(Probe:)** By primary care specialties, we mean general or family practice, general pediatrics, or general internal medicine.

**EMPPCP**

1 Yes
2 No
8 (DK)
9 (Refused) _____(1641)

**(All in C3ab, Skip to C7)**

C3ac. **(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, ask:)** Are any of the physicians in the practice in specialties other than general or family practice, general pediatrics or general internal medicine?

**EMPSPEC**

1 Yes
2 No
8 (DK)
9 (Refused) _____(1642)

**(All in C3ac, Skip to C7)**

C3a. **(If code 14 in C3, ask:)** Is this a hospital, clinic, or some other setting?

**OTHSET**

1 Hospital
2 Clinic
3 Other (do NOT list)

8 (DK)
9 (Refused) _____(1198)

**(If code 1 in C3a, Skip to CX;
Otherwise, Skip to Note before C8a)**

C3b. **(If code 01, 98, or 99 in C3, ask:)** Are you employed by **(read 11-21, 22, 25, and 26, as appropriate, then 01)**?

**EMPTYP**

01 OR, something else (do NOT list here)

02-
10 HOLD

11 Other HMO, insurance company, or health plan
15 An integrated health or delivery system
17 A physician practice management company or other for-profit investment company
18 Community health center
19 Management Services Organization (MSO)
20 Physician-Hospital Organization (PHO)
21 Locum tenens
22 Foundation
25 Independent contractor
26 Industry clinic

98 (DK)
99 (Refused)

_____ _____
_____ (1199) (1200)

**(If code 01 in C3b, Continue;
If code 18, 98, or 99 in C3b, Skip to C7;
If code 22 in C3b, Skip to C3ca;
Otherwise, Skip to Note before C8a)**

C3c. What type of organization do you work for? (Open ended and code, **if possible; otherwise, ENTER VERBATIM RESPONSE)**

**EMPTYP2**

01 Other (list)

02-
05 HOLD

06 A practice owned by one physician (solo practice)
07 A two physician-owned practice
08 A group practice of three or more physicians (see) AMA definition on card)
09 A group model HMO
10 A staff model HMO
12 A medical school or university
13 A non-government hospital or group of hospitals
14 City, county or state government
16 A free-standing clinic
17 HOLD
18 Community health center
19-
21 HOLD
22 Foundation
25 Independent Contractor
26 Industry Clinic

98 (DK)
99 (Refused)

_____ _____
(1643) (1644)

_____

**(If code 01, 25, or 26 in C3c, Skip to Note before C8a;**
**If code 06, 07, 09, 10, 18, 98, or 99 in C3c, Skip to C7;**
**If code 08, 16, or 22 in C3c, Continue;**
**If code 12 or 13 in C3c, Skip to C6b;**
**Otherwise, Skip to C3d)**

C3ca. **(If code 08, 16, or 22 in C3c or code 22 in C3b, ask:)** Is the practice a single-specialty or multi-specialty practice?

**EM2NSPC**

1 Single-specialty - **(Skip to C7)**

2 Multi-specialty - **(Continue)**

8 (DK) **(Skip to C7)**
9 (Refused) **(Skip to C7)** _____(1097)

**(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, Skip to C3cc; Otherwise, Continue)**

C3cb. Are any of the physicians in the practice in primary care specialties? By primary care specialties, we mean general or family practice, general pediatrics, or general internal medicine.

**EM2PCP**

1 Yes
2 No
8 (DK)
9 (Refused) _____(1098)

**(All in C3cb, Skip to C7)**

C3cc. **(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10 OR A8, OR If code 1, 8, or 9 in A9 OR If code 042, 088, or 137 in A10 OR If code 2 or 3 in A9a OR If code 2 or 3 in A9b, ask:)** Are any of the physicians in the practice in specialties other than general or family practice, general pediatrics, or general internal medicine?

**EM2SPEC**

1 Yes
2 No
8 (DK)
9 (Refused) _____(1099)

**(All in C3cc, Skip to C7)**

C3d. **(If code 14 in C3c, ask:)** Is this a hospital, clinic, or some other setting?

**EM2HOSP**

1 Hospital
2 Clinic
3 Other (do NOT list)

8 (DK)
9 (Refused) _____(1662)

**(If code 1 in C3d, Skip to CX;
Otherwise, Skip to Note before C8a)**

**(Questions C4-C6a deleted)**

[Deleted Note]

C6b. In which of the following settings do you spend most of your time seeing patients - in an office practice owned by the hospital or a university or medical school, on hospital staff, in the emergency room, in a hospital clinic, or somewhere else?

**SETTING**

01 Somewhere else (list)
02 (DK)
03 (Refused)
04 HOLD
05 HOLD

06 Office practice owned by the (hospital/university/medical school)
07 On hospital staff
08 In emergency room
09 In a hospital clinic

_____ _____
_____ (3217) (3218)

**(If code 07 or 08 in C6b, Skip to CX;
If code 01, 02, 03, or 09 in C6b,
Skip to Note before C8a;
Otherwise, Continue)**

C7. How many physicians, including yourself, are in the practice? Please include all locations of the practice. **(Probe:)** Your best estimate would be fine. (Open ended **and code actual number)** **(INTERVIEWER NOTE: If asked, this includes both full- and part-time physicians)**

**NPHYS**

997 997+
DK (DK)
RF (Refused)

_____ _____ (1148 - 1150)

_____

**(Question C8 deleted)** HOLD _____(1151-1153)

**(If code 2 in S1c OR**
**If response in A6 is less than 2002, DK, or RF, Continue;**
**Otherwise, Skip to Note before C9)**

C8a. The next question is about the overall level, that is, the quality and number of nurses, including RNs, LPNs, nurse aides, and assistants, who work in your practice. Compared with three years ago, is the overall level of nursing support in your practice much better, slightly better, about the same, slightly worse, or much worse?

**NURSLEV**

5 Much better
4 Slightly better
3 About the same
2 Slightly worse
1 Much worse

6 (DK)
7 (Refused) _____(1159)

**(If code 1 or 2 in C8a, Continue;**
**Otherwise, Skip to Note before C9)**

C8aa. Has the overall level of nursing support worsened mainly because you have fewer nurses, mainly because nursing quality has declined, or both about equally?

1 Fewer nurses
2 Nursing quality has declined
3 (Both about equally)
4 (DK)
5 (Refused) _____(1160)

**(If code 06 in C6b, Skip to CX; If code 08 in C2 or C3 AND code 025-997 in C7, Continue; Otherwise, Skip to CX)**

C9. Is your practice either a group model HMO or organized exclusively to provide services to a group model HMO?

**GRPHMO**

1 Yes
2 No
8 (DK)
9 (Refused) _____(1154)

**(Questions C10-C12 deleted)**

CX. How would you describe your overall personal financial incentives in your practice? On balance, do these incentives favor reducing services to individual patients, favor expanding services to individual patients, or favor neither?

**INCENT**

1 Reducing services to individual patients **(Continue)**
2 Expanding services to individual patients **(Continue)**

3 Favor neither - **(Skip to CZ)**

8 (DK) **(Skip to CZ)**
9 (Refused) **(Skip to CZ)** _____(3271)

CY. **(If code 1 or 2 in CX, ask:)** Have these incentives [**(if code 1 in CX, say:)** reduced/**(if code 2 in CX, say:)** expanded] services a little, a moderate amount, or a lot?

**EFINCNT**

1 A little
2 A moderate amount
3 A lot

4 (None)
8 (DK)
9 (Refused) _____(3272)

CZ. The next question deals with your perception of competition among physicians. By competition among physicians, we mean pressure to undertake various activities to attract and retain patients. Now, thinking about your practice specifically, how would you describe the competitive situation your practice faces? Would you say very competitive, somewhat competitive, or not at all competitive?

**COMPETE**

3 Very competitive
2 Somewhat competitive
1 Not at all competitive

8 (DK)
9 (Refused) _____(3273)

CLOCK:

_____ _____
_____ (2192 - 2195)

# ***SECTION D***
# *MEDICAL CARE MANAGEMENT; INFORMATION TECHNOLOGY; CARE MANAGEMENT; HOSPITAL SAFETY; SCOPE OF CARE*

## ***INFORMATION TECHNOLOGY***

D1. The next question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients. In your practice, are computers or other forms of information technology used **(read and rotate A-H)**? **(INTERVIEWER NOTE: "Practice" refers to main practice)**

1 Yes
2 No
8 (DK)
9 (Refused)

**IT TRT**

A. To obtain information about treatment alternatives or recommended guidelines _____(3227)

**IT FORM**

B. To obtain information on formularies _____(3228)

**ITRMNDR**

C. To generate reminders for you about preventive services _____(3229)

**ITNOTES**

D. To access patient notes, medication lists, or problem lists _____(3230)

**ITPRESC**

E. To write prescriptions _____(3231)

**ITCLIN**

F. For clinical data and image exchanges WITH OTHER PHYSICIANS _____(3232)

**ITHOSP**

F1. For clinical data and image exchanges WITH HOSPITALS AND LABORATORIES _____(3444)

D1. (Continued:)

**ITCOMM**

G. To communicate about clinical issues with patients by e-mail _____(3233)

**ITDRUG**

H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions _____(3251)

**(If code 1 in D1-E, Continue; Otherwise, Skip to D3)**

**(Question D2 deleted)**

**(There are no questions D2a and D2b)**

D2aa. What percentage of the prescriptions that you order are written electronically? (Open ended **and code actual percent)**

**EPRESC**

000 None
101 Less than 1%
102 (DK)
103 (Refused)

_____ _____
_____ (3445 - 3447)

[Deleted Note]

**(Questions D2ab-D2ad deleted)** HOLD _____(3448-3450)

**CARE MANAGEMENT**

D3. What percentage of your patients have prescription coverage that includes the use of a formulary? **(INTERVIEWER NOTE: A formulary is a restriction on the types of prescription drugs insurance companies will cover)** (Open ended **and code actual percent)**

**FORMLRY**

000 None
101 Less than 1%
102 (DK)
103 (Refused)

_____ _____
_____ (3237 - 3239)

[Deleted Read]

**(Question D4 deleted)**

D4-A. How large an effect does your use of FORMAL, WRITTEN practice guidelines such as those generated by physician organizations, insurance companies, or HMOs, or government agencies have on your practice of medicine? **(INTERVIEWER NOTE: Exclude guidelines that are unique to the physician.)** [**(If physician says that he/she uses his/her own guidelines, say:)** In this question, we are only interested in the use of formal, written guidelines such as those generated by physician organizations, insurance companies or HMOs, or other such groups.] Would you say that the effect is **(read 5-0)**?

**EFGUIDE**

5 Very large
4 Large
3 Moderate
2 Small
1 Very small, OR
0 No effect at all

8 (DK)
9 (Refused) _____(1157)

D4-A1. **(If code 0 in D4-A, ask:)** Is that because you are not aware of guidelines that pertain to conditions you typically treat, or because you are aware of them, but they have no effect on conditions you treat?

**AWRGUID**

1 Not aware
2 Aware, no effect

8 (DK)
9 (Refused) _____(1158)

**(D4-B, D4-B1, D4-C, D4-C1, and D5 deleted)** HOLD _____(3242-3250)

**(There is no question D6)** HOLD _____(3251-3255)

**HOSPITAL SAFETY**

[Deleted CLOCK] HOLD _____(3280-3283)

**(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10/A8, OR**
**If code 1, 8, or 9 in A9, OR**
**If code 042, 088, or 137 in A10, OR**
**If code 2 or 3 in A9a, OR**
**If code 2 or 3 in A9b, AND**
**If code 000, 998, or 999 in B5a-D, Skip to D7;**
**Otherwise, Continue)**

D6a. Does the hospital where most of your patients are treated have computerized systems to order tests and medications?

**CPOEHSP**

1 Yes
2 No
3 (Not applicable; Do not admit patients to hospital)
8 (DK)
9 (Refused) _____(3451)

D6b. Medical errors include events such as dispensing of incorrect medication doses, surgical mistakes, or error in interpreting results of diagnostic tests. Does the hospital where most of your patients are treated have a system for reporting medical errors, in which the person reporting the error remains anonymous? **(If necessary to clarify term "medical errors", read:)** Some errors harm patients, some are caught before they can cause any harm, and others may occur but don't cause any harm.

**ERRREPT**

1 Yes
2 No
3 (Not applicable; Do not admit patients to hospital)
8 (DK)
9 (Refused) _____(3452)

D7. Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients. What percentage of your patients who were hospitalized last year had a hospitalist involved in their inpatient care? (Open ended **and code actual percent)**

**HSPLST**

000 None
101 Less than 1%
102 (DK)
103 (Refused)
104 (Not applicable/Do not admit patients to hospital)

_____ _____
_____ (3453 - 3455)

[Deleted CLOCK] HOLD _____(3284-3287)

**(If code 019-020, 023, 043, 085, 133, 195, or 403 in A10/A8, OR**
**If code 1, 8 or 9 in A9, OR**
**If code 042, 088, or 137 in A10, OR**
**If code 2 or 3 in A9a, OR**
**If code 2 or 3 in A9b, Continue;**
**Otherwise, Skip to CLOCK before F1)**

**PCP SCOPE OF CARE, GATEKEEPING**

**(READ:)** Now, I would like to ask you a couple of questions about the range and complexity of conditions you treat without referral to specialists.

D8. In general, would you say that the complexity or severity of patients' conditions for which you are currently expected to provide care without referral is **(read 5-1)**?

**CMPEXPC**

5 Much greater than it should be
4 Somewhat greater than it should be
3 About right
2 Somewhat less than it should be, OR
1 Much less than it should be

8 (DK)
9 (Refused) _____(1170)

D9. During the last two years, has the number of patients that you refer to specialists **(read 5-1)**?

**SPECUSE**

5 Increased a lot
4 Increased a little
3 Stayed about the same
2 Decreased a little, OR
1 Decreased a lot

8 (DK)
9 (Refused) _____(1171)

D10. Some insurance plans or medical groups REQUIRE their enrollees to obtain permission from a primary care physician before seeing a specialist. For roughly what percent of your patients do you serve in this role? (Open ended **and code actual percent)**

**(If necessary, say:)** The term "gatekeeper" is often used to refer to this role.

**(If necessary, say:)** Include only those patients for whom it is required, not for patients who choose to do so voluntarily.

**PCTGATE**

000 None **(Skip to CLOCK before F1)**
001 1% or less **(Skip to CLOCK before F1)**

002-
100 **(Skip to CLOCK before F1)**

DK (DK) **(Continue)**
RF (Refused) **(Continue)**

_____ _____
_____ (1172 - 1174)

D10a. **(If code DK or RF in D10, ask:)** Would you say you serve in this role for **(read 1-2)**?

**PGATE25**

1 Less than 25 percent of your patients, OR - **(Skip to D10c)**

2 25 percent or more of your patients - **(Continue)**

8 (DK) **(Skip to CLOCK before F1)**
9 (Refused) **(Skip to CLOCK before F1)** _____(1175)

D10b. **(If code 2 in D10a, ask:)** Would you say for **(read 1-2)**?
**PGATE50**

1 Less than 50 percent of your patients
2 50 percent or more of your patients

8 (DK)
9 (Refused) _____(1176)

**(All in D10b, Skip to CLOCK before F1)**

D10c. **(If code 1 in D10a, ask:)** Would you say for **(read 1-2)**?
**PGATE10**

1 Less than 10 percent of your patients
2 10 percent or more of your patients

8 (DK)
9 (Refused) _____(1177)

[Deleted Note]

**(There are no questions D11, D12, or D13)**

**(Question D14 deleted)** HOLD _____(3456)

CLOCK:

_____ _____
_____ (2200 - 2204)

**(There is no Section E)**

# *SECTION F*
# *PHYSICIAN-PATIENT INTERACTIONS; QUALITY; ABILITY TO OBTAIN SERVICES; COST SHARING; NEW PATIENTS*

## PERCEPTIONS OF QUALITY

F1. Next I am going to read you several statements. For each, I'd like you to tell me if you agree strongly, agree somewhat, disagree somewhat, disagree strongly, or if you neither agree nor disagree. [**(If necessary, say:)** As you answer, please think only about your main practice.] **(Read A-B, as appropriate, then read and rotate C-H, as appropriate)** Do you **(read 5-1)**? **(If necessary, say:)** We'd like you to think across all patients that you see in your practice.

5 Agree strongly
4 Agree somewhat
3 Neither agree nor disagree
2 Disagree somewhat, OR
1 Disagree strongly

7 (Doctor does not have office) [A only]
7 (Doctor does not have continuing relationship with patients) [H only]
8 (DK)
9 (Refused)

**ATMOFF**

A. I have adequate time to spend with my patients during their office visits? **(INTERVIEWER NOTE: Do not further differentiate the level of visit, that is, whether brief, intermediate, etc.)** **(If necessary, say:)** We would like you to answer in general or on AVERAGE over all types of visits. _____(1308)

**ATMOTH**

B. **(If code 7 in F1-A, ask:)** I have adequate time to spend with my patients during a typical patient visit **(INTERVIEWER NOTE: This does not include surgery)** _____(1351)

**CLNFREE**

C. I have the freedom to make clinical decisions that meet my patients' needs _____(1309)

**HIGHCAR**

D. It is possible to provide high quality care to all of my patients _____(1310)

F1. (Continued:)

**NEGINCN**

E. I can make clinical decisions in the best interests of my patients without the possibility of reducing my income _____(1311)

**(Items F and G deleted)** HOLD _____(1312-1313)

**PATREL**

H. It is possible to maintain the kind of continuing relationships with patients over time that promote the delivery of high quality care _____(1314)

**(There are no questions F2-F7)**

## ABILITY TO OBTAIN SERVICES

**(Question F8 and F8a deleted)**

[Deleted CLOCK] HOLD _____(3462-3465)

F8b. During the last 12 months, were you unable to obtain any of the following services for your patients when you thought they were medically necessary? How about **(read and rotate A-E, as appropriate)**?

1 Yes
2 No
8 (DK)
9 (Refused)

**NOTREFS**

A. [**(If code 019, 020, 023, 043, 085, 133, 195, or 403 in A10/A8, OR code 1, 8, or 9 in A9, or if code 042, 088, or 137 in A10, OR code 2 or 3 in A9a, OR code 2 or 3 in A9b, ask:)** Referrals to specialists of high quality/**(Otherwise, ask:)** Referrals to other specialists of high quality] _____(3457)

**(Item B deleted)** HOLD _____(3458)

**NOTHOSP**

C. Non-emergency hospital admissions _____(3459)

**NOTIMAG**

D. High quality diagnostic imaging services _____(3460)

**NOTOUTP**

E. **(If code 010, 019, 020, 023, 043, 062, 064-065,**

**082-085, 127, 132, 133, 210, 312, 313, 192, 195, or 403 in A10/A8, OR code 1, 8, or 9 in A9, or code 2 or 3 in A9a, or code 042, 088 or 137 in A10, OR code 2 or 3 in A9b, ask:)** High quality outpatient mental health services _____(3461)

[Deleted CLOCK] HOLD _____(3466-3469)

F8c. Now, I am going to read some reasons why you might be unable to obtain various services. For each one, tell me whether it is a very important, moderately important, not very important, or not at all important reason for your being unable to obtain **(read A-C, as appropriate)**. How about **(read and rotate a-c)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

A. **(If code 1 in F8b-A, ask:)** [**(If code 019, 020, 023, 043, 085, 133, 195, or 403 in A10/A8, OR code 1, 8, or 9 in A9, or if code 042, 088, or 137 in A10, OR code 2 or 3 in A9a, OR code 2 or 3 in A9b, ask:)** Referrals to specialists of high quality/**(Otherwise, ask:)** Referrals to other specialists of high quality]

**REFPRVR**

a. There aren't enough qualified service providers or facilities in my area _____(3470)

**REFHPR**

b. Health plan networks and administrative barriers limit patient access _____(3471)

**REFINSR**

c. Patients lack health insurance or have inadequate insurance coverage _____(3472)

B. **(If code 1 in F8b-C, ask:)** Non-emergency hospital admissions

**HSPPRVR**

a. There aren't enough qualified service providers or facilities in my area _____(3473)

**HSPHPR**

b. Health plan networks and administrative barriers limit patient access _____(3474)

**HSPINSR**

c. Patients lack health insurance or have inadequate insurance coverage _____(3475)

F8c. (Continued:)

C. **(If code 1 in F8b-E, ask:)** High quality outpatient mental health services, when you think it is medically necessary

**MHPROVR**

a. There aren't enough qualified service providers or facilities in my area _____(3476)

**MHHPR**

b. Health plan networks and administrative barriers limit patient access _____(3477)

**MHINSR**

c. Patients lack health insurance or have inadequate insurance coverage _____(3478)

**COST SHARING**

[Deleted CLOCK] HOLD _____(3479-3482)

F8d. The next questions concern the impact of insured patients' out-of-pocket costs for co-payments and deductibles. **(Read and rotate A-C)**

5 Always
4 Usually
3 Sometimes
2 Rarely
1 Never

8 (DK)
9 (Refused)

**GENERIC**

A. If a generic option is available, how often do you prescribe a generic over a brand name drug? **(Read 5-1)** _____(3483)

**DIAGCST**

B. If there is uncertainty about a diagnosis, how often do you consider an insured patient's out-of pocket costs in deciding the types of tests to recommend? **(Read 5-1)** _____(3484)

**IOPTCST**

C. If there is a choice between outpatient and inpatient care, how often do you consider an insured patient's out-of-pocket costs? **(Read 5-1)** _____(3485)

[Deleted CLOCK] HOLD _____(3486-3489)

**NEW PATIENTS**

F9. Now, I'd like to ask you about new patients the practice in which you work might be accepting. Is the practice accepting all, most, some, or no **(read A-G, as appropriate)**? **(INTERVIEWER NOTE: Refers to entire practice not just to physician's own patients. Medicaid and Medicare beneficiaries who are enrolled in managed care plans should be included in A or B, respectively.)**

4 All
3 Most
2 Some
1 No new patients/None

8 (DK)
9 (Refused)

NWMCARE

A. New patients who are insured through Medicare, including Medicare managed care patients _____(1323)

NWMCAID

B. [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** New patients who are insured through MediCAL, including MediCAL managed care patients/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code AZ in A5a-STATE}, read:)** New patients who are insured through AHCCCS ("Access")/**(Otherwise, read:)** New patients who are insured through Medicaid, including Medicaid managed care patients _____(1322)

**(Item B1 deleted)** HOLD _____(3490)

NWPRIV

C. New patients who are insured through private or commercial insurance plans including managed care plans and HMOs with whom the practice has contracts. **(If necessary, read:)** This includes both fee for service patients and patients enrolled in managed care plans with whom the practice has a contract. It excludes Medicaid or Medicare managed care _____(1324)

**(Item D deleted)** HOLD _____(3269)

**(There are no Items E or F)**

NWNPAY

G. New uninsured patients who are unable to pay your fees _____(3495)

**(Question F10 deleted)** HOLD _____(3270)

[Deleted CLOCK] HOLD _____(3491-3494)

**(If code 1 or 2 in F9-A, Continue; Otherwise, Skip to Note before F12)**

F11. I am going to read some reasons why physician practices may be limiting or not accepting new Medicare patients. For each one, tell me whether it is a very important, moderately important, not very important, or not at all important reason why your practice is [**(If code 1 in F9-A, read:)** not accepting/**(If code 2 in F9-A, read:)** limiting] new Medicare patients. How about **(read and rotate A-E)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

**MRBILL**

A. Billing requirements, including paperwork, and filing of claims _____(3496)

**MRAUDIT**

B. Concern about a Medicare audit _____(3497)

**MRREIMB**

C. Inadequate reimbursement _____(3498)

**MRNUFPT**

D. Practice already has enough patients _____(3499)

**MRPTBUR**

E. Medicare patients have high clinical burden _____(3500)

**(If code 1 or 2 in F9-B, Continue; Otherwise, Skip to CLOCK after F12)**

F12. Next, I am going to read some reasons why physician practices may be limiting or not accepting new [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCal/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access")/**(Otherwise, read:)** Medicaid] patients. Again, tell me whether each one is a very important, moderately important, not very important, or not at all important reason why your practice is [**(If code 1 in F9-B, read:)** not accepting/**(If code 2 in F9-B, read:)** limiting] new [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCal/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access")/**(Otherwise, read:)** Medicaid] patients. How about **(read and rotate A-E)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

**MDBILL**
A. Billing requirements, including paperwork, and filing of claims _____(3501)

**MDDELAY**
B. Delayed reimbursement _____(3502)

**MDREIMB**
C. Inadequate reimbursement _____(3503)

**MDNUFPT**
D. Practice already has enough patients _____(3504)

**MDPTBUR**
E. [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCal/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access")/**(Otherwise, read:)** Medicaid] patients have high clinical burden _____(3505)

CLOCK:

_____ _____
(2216 - 2219)

_____

## ***SECTION G***
## ***PRACTICE REVENUE***

G1. Now, I'm going to ask you some questions about the patient care revenue received by the **(response in CA)** in which you work. Approximately what percentage of the PRACTICE REVENUE FROM PATIENT CARE would you say comes from **(read A-B)**? (Open ended **and code actual percent)** **(Probe:)** Your best estimate will be fine. **(If necessary, say:)** We're asking about the patient care revenue of the practice in which you work, not just the revenue from the patients YOU see. **(INTERVIEWER NOTE: "Other public insurance" includes Champus, Champva, and Tricare)**

000 None
001 1% or less
DK (DK)
RF (Refused)

**PMCR A**

A. Payments from all Medicare plans, including Medicare managed care

_____ _____
(1325 - 1327)

_____

**PMCD A**

B. [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** Payments from MediCAL or any other public insurance, including MediCAL managed care/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** Payments from AHCCCS ("Access") or any other public insurance/**(Otherwise, read:)** Payments from Medicaid or any other public insurance, including Medicaid managed care]

_____ _____
(1328 - 1330)

_____

**(If response in G1-A + response in G1-B > 100, Continue; Otherwise, Skip to G3)**

G1a. I have recorded that the combined practice revenue from Medicare and [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCAL/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access")/**(Otherwise, read:)** Medicaid] is greater than 100 percent, can you help me resolve this? Approximately what percentage of the practice's revenue from patient care comes from **(read A-B)**? **(INTERVIEWER NOTE: Revenue from patients covered by both Medicare and Medicaid should be counted in MEDICARE ONLY)** (Open ended **and code actual percent)** **(Probe:)** Your best estimate will be fine. **(If necessary, say:)** We're asking about the patient care revenue of the practice in which you work, not just the revenue from the patients YOU see.

000 None
001 1% or less
DK (DK)
RF (Refused)

**PMCR B**

A. Payments from all Medicare plans, including Medicare managed care

_____ _____
(1334 - 1336)

_____

**PMCD B**

B. [**({If code 06 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND code CA in A5a-STATE}, read:)** MediCAL/**({If code 04 in **STATE AND code 1 in A5} OR {If code 2, 8, 9, or BLANK in A5 AND AZ in A5a-STATE}, read:)** AHCCCS ("Access")/**(Otherwise, read:)** Medicaid]

_____ _____
(1337 - 1339)

_____

**(There is no question G2)**

[Deleted Note]

G3. Now, again thinking about the patient care revenue from ALL sources received by the practice in which you work, what percentage is paid on a capitated or other prepaid basis? **(If necessary, say:)** Under capitation, a fixed amount is paid per patient per month regardless of services provided. **(Probe:)** Your best estimate would be fine. (Open ended **and code actual percent)** **(INTERVIEWER NOTE: Includes payments made on a capitated or other prepaid basis from Medicare or Medicaid)**

**PCAP A**

000 None
001 1% or less
002-
100
DK (DK)
RF (Refused)

_____ _____
_____ (2438 - 2440)

**(There are no questions G3a-G5)**

[Deleted Note]

**(Question G5a deleted)** HOLD _____(3509-3514)

**(Question G5b deleted)**

G6. Thinking again about the practice in which you work, we have a few questions about contracts with managed care plans such as HMOs, PPOs, IPAs, and Point-Of-Service plans. First, roughly how many managed care contracts does the practice have? **(Probe:)** Your best estimate would be fine. **(If necessary, say:)** Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. **(INTERVIEWER NOTE: Include Medicare managed care, Medicaid managed care, and other government managed care contracts but not traditional Medicare or Medicaid.)** (Open ended **and code actual number)**

**NMC A**

| | | |
|---|---|---|
| 00 | None - | **(Skip to G7)** |
| 01-19 | | **(Skip to G8)** |
| 20-97 | | **(Skip to G6b)** |
| 98 | 98+ contracts | **(Skip to G6b)** |
| DK | (DK) | **(Continue)** |
| RF | (Refused) | **(Continue)** |

_____ _____
_____ (2458) (2459)

G6a. **(If code DK or RF in G6, ask:)** Would you say less than 3 contracts, 3 to 10, or more than 10 contracts?

**NMCCAT**

| | | |
|---|---|---|
| 0 | (None) - | **(Skip to G7)** |
| 1 | Less than 3 (1 or 2) | **(Skip to G8)** |
| 2 | 3 to 10 | **(Skip to G8)** |
| 3 | More than 10 (11+) | **(Skip to G8)** |
| 8 | (DK) | **(Skip to G8)** |
| 9 | (Refused) | **(Skip to G8)** |

_____(2460)

G6b. **(If code 20-97 in G6, ask:)** Just to be sure, is this the number of contracts, or patients?

**CONPATS**

1 Contracts - **(Skip to G8)**

2 Patients - **(Continue)**

8 (DK) **(Skip to G8)**
9 (Refused) **(Skip to G8)** _____(1340)

G6c. **(If code 2 in G6b, ask:)** In this question, we are asking about contracts. So, roughly how many managed care CONTRACTS does the practice have? (Open ended **and code actual number)**

**NMC B**

00 None - **(Continue)**

01-
97 **(Skip to G8)**

DK (DK) **(Skip to G8)**
RF (Refused) **(Skip to G8)**

_____ _____
_____ (1341) (1342)

G7. **(If code 00 in G6, or code 0 in G6a, or code 00 in G6c, ask:)** What percentage, if any, of the patient care revenue received by the practice in which you work comes from all managed care combined? Please include ALL revenue from managed care including, but not limited to, any payments made on a capitated or prepaid basis. **(Probe:)** Your best estimate will be fine. **(If necessary, say:)** Managed care programs include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended **and code actual percent)**

**PMC A**

000 None
001 1% or less
DK (DK)
RF (Refused)

_____ _____
(1343 - 1345)

_____

**(If code 00 in G6,**
**and G7 is LESS THAN response in G3, Continue;**
**If code 00 in G6a or G6c,**
**And G7 is LESS THAN response in G3, Continue;**
**Otherwise, Skip to CLOCK before Section H)**

G7a. I may have recorded something incorrectly. I recorded that the percentage of practice revenue from all managed care is less than the percentage of practice revenue that is paid on a capitated or other prepaid basis. This seems inconsistent, so let me ask you again, what percent of patient care revenue received by the practice in which you work comes from all managed care combined? (Open ended **and code actual percent)** **(SURVENT: Show response in G7)**

**PMC F**

000 None
101 Less than 1%
DK (DK)
RF (Refused)

_____ _____
(2548 - 2550)

_____

G7b. Let me also ask you again, thinking about the patient care revenue from ALL sources received by the practice in which you work, what percentage is paid on a capitated or other prepaid basis? (Open ended **and code actual percent)** **(SURVENT: Show response in G3)**

**PCAP D**

000 None
101 Less than 1%
DK (DK)
RF (Refused)

_____ _____
(2551 - 2553)

_____

**(All in G7b, Skip to CLOCK before Section H)**

G8. **(If code 02-97 in G6c, or code 1-3 in G6a, or code 02-97 in G6, ask:)** What percentage of the patient care revenue received by the practice in which you work comes from these **(response in G6c/G6a/G6)** managed care contracts combined? [**(If code 001-100, DK, or RF in G3, say:)** Please include ALL revenue from these contracts including, but not limited to, any payments made on a capitated or prepaid basis.] **(Probe:)** Your best estimate will be fine. **(If necessary, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended **and code actual percent)**

**(If code 01 in G6c or G6, ask:)** What percentage of the patient care revenue received by the practice in which you work comes from this managed care contract? [**(If code 001-100, DK, or RF, say:)** Please include ALL revenue from this contract including, but not limited to, any payments made on a capitated or prepaid basis.] **(Probe once lightly:)** Your best estimate will be fine. **(If necessary, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended **and code actual percent)**

G8. (Continued:)

**(If code "DK" or "RF" in G6c, or code 8 or 9 in G6a, ask:)** What percentage of the patient care revenue received by the practice in which you work comes from all of the practice's managed care contracts combined? [**(If code 001-100, DK, or RF, say:)** Please include ALL revenue from these contracts including, but not limited to, any payments made on a capitated or prepaid basis.] **(Probe once lightly:)** Your best estimate will be fine. **(If necessary, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended **and code actual percent)**

**PMC B**

| | | |
|---|---|---|
| 000 | None | **(Continue)** |
| 001 | 1% or less | **(Continue)** |
| 002-100 | | **(Continue)** |
| DK | (DK) | **(Skip to CLOCK before Section H)** |
| RF | (Refused) | **(Skip to CLOCK before Section H)** |

_____ _____
(2462 - 2464)

_____

**(If response in G8 is less than response in G3, Continue;**
**If response in G3 + response in G8=0, Skip to CLOCK before Section H;**
**If response in G8 > 000, Skip to G8d)**

G8a. **(If response in G8 is less than response in G3, ask:)** I have recorded that your revenue from all managed care contracts is less than the amount you received on a capitated or prepaid basis. We would like you to include all capitated payments in estimating managed care revenue. Would you like to change your answer of **(read 1-2)**?

**FIXPMC**

1 **(Response in G8)** percent from all managed care contracts - **(Continue)**

OR

2 **(Response in G3)** percent received on a capitated or prepaid basis - **(Skip to G8c)**

3 (Both) - **(Continue)**

4 (Neither) **(Skip to CLOCK before Section H)**
8 (DK) **(Skip to CLOCK before Section H)**
9 (Refused) **(Skip to CLOCK before Section H)** _____(2465)

**(If code 01-19 in G6, Skip to G8b;**
**If code 20-97 in G6,**
**AND code 1 in G6b, Skip to G8b;**
**If code 8, 9 or BLANK in G6a, AND**
**code DK, RF, or BLANK in G6c, Skip to G8d;**
**Otherwise, Continue)**

G8b. **(If code 1 or 3 in G8a, ask:)**
**(If code 02-97 in G6c, or code 1-3 in G6a or code 02-97 in G6, ask:)** So, what percentage of the practice's revenue from patient care would you say comes from all of these managed care contracts combined? (Open ended **and code actual percent)**
**(If code 01 in G6c or G6, ask:)** So, what percentage of the practice's revenue from patient care would you say comes from this managed care contract? (Open ended **and code actual percent)**

**PMC C**

000 None - **(Skip to CLOCK before Section H)**

001 1% or less
DK (DK)
RF (Refused)

_____ _____
(2466 - 2468)

_____

G8c. **(If code 2 or 3 in G8a, ask:)** So what percentage of patient care revenue received by the practice in which you work is paid on a capitated or other prepaid basis? **(If necessary, say:)** Under capitation, a fixed amount is paid per patient per month regardless of services provided. **(Probe:)** Your best estimate would be fine. (Open ended **and code actual percent)**

**PCAP B**

000 None
001 1% or less

002-
100

DK (DK)
RF (Refused)

_____ _____
_____ (1352 - 1354)

G8d. **(If "specific" response in G8b/G8 = "specific" response in G8c/G3, ask:)** So, all of the practice's managed care revenue is paid on a capitated, or prepaid basis, is this correct?

**ALLCAP**

1 Yes - **(Skip to CLOCK before Section H)**

2 No - **(Continue)**

8 (DK) **(Skip to CLOCK before Section H)**
9 (Refused) **(Skip to CLOCK before Section H)** _____(1346)

G8e. **(If code 2 in G8d, ask:)** I have recorded that **(response in G8b/G8)** percent of the practice revenue is from managed care and that **(response in G8c/G3)** percent of the practice revenue is paid on a capitated or prepaid basis. Which of these is incorrect?

**FIXCAP**

1 Revenue from managed care - **(Continue)**

2 Revenue paid on capitated or prepaid basis - **(Skip to G8g)**

3 Both are correct - **(Skip to CLOCK before Section H)**

4 Neither are correct - **(Continue)**

8 (DK) **(Skip to CLOCK before Section H)**
9 (Refused) **(Skip to CLOCK before Section H)** _____(1347)

G8f. **(If code 1 or 4 in G8e, ask:)**
**(If code 02-97 in G6c, or G6 or code 1-3 in G6a, ask:)**
What percentage of the patient care revenue received by the practice in which you work comes from these [**(response in G6c/G6)**] managed care contracts combined? **(If code 001-100, DK, or RF in G3, say:)** Please include ALL revenue from these contracts including, but not limited to, any payments made on a capitated or prepaid basis. **(Probe:)** Your best estimate will be fine. **(If necessary, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended **and code actual percent)**

G8f. (Continued:)

**(If code 01 in G6c or G6, ask:)** What percentage of the patient care revenue received by the practice in which you work comes from this managed care contract? Please include ALL revenue from this contract including, but not limited to, any payments made on a capitated or prepaid basis. **(Probe:)** Your best estimate will be fine. **(If necessary, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended **and code actual percent)**

**(If code DK or RF in G6c or code 8 or 9 in G6a, ask:)** What percentage of the patient care revenue received by the practice in which you work comes from all of the practice's managed care contracts combined? Please include ALL revenue from these contracts including, but not limited to, any payments made on a capitated or prepaid basis. **(Probe:)** Your best estimate will be fine. **(If necessary, say:)** Managed care contracts include, but are not limited to those with HMOs, PPOs, IPAs, and point-of-service plans. **(If necessary, say:)** Managed care includes any type of group health plan using financial incentives or specific controls to encourage utilization of specific providers associated with the plan. Direct contracts with employers that use these mechanisms are also considered managed care. (Open ended **and code actual percent)**

**PMC D**

| | | |
|---|---|---|
| 000 | None - | **(Skip to CLOCK before Section H)** |
| 001 | 1% or less | **(Continue)** |
| 002-100 | | **(Continue)** |
| DK | (DK) | **(Continue)** |
| RF | (Refused) | **(Continue)** |

_____ _____
_____ (1161 - 1163)

G8g. **(If code 2 or 4 in G8e, ask:)** Now thinking about the patient care revenue from ALL sources received by the practice in which you work, what percentage is paid on a capitated or other prepaid basis? **(If necessary, say:)** Under capitation, a fixed amount is paid per patient per month regardless of services provided. **(Probe:)** Your best estimate would be fine. (Open ended **and code actual percent)** **(INTERVIEWER NOTE: Includes payments made on a capitated or other prepaid basis from Medicare or Medicaid)**

**PCAP C**

000 None
001 1% or less

002-
100

DK (DK)
RF (Refused)

_____ _____
_____ (1191 - 1193)

[Deleted Note]

**(There are no questions G9-G10)**

**(There is no question G11)**

**(There is no question G12)**

CLOCK:

_____ _____
_____ (2224 - 2227)

# *SECTION H*
# *PHYSICIAN COMPENSATION METHODS AND INCOME LEVEL*

**(If code 1 in C1, AND code 06 in C2, Skip to H15a; Otherwise, Continue)**

**(READ:)** Now, I'm going to ask you a few questions about how your practice compensates you personally. **(If necessary, say:)** Please answer only about the main practice in which you work.

H1. Are you a salaried physician?
**SALPAID**

| | | |
|---|---|---|
| 1 | Yes - | **(Skip to H3)** |
| 2 | No | **(Continue)** |
| 8 | (DK) | **(Continue)** |
| 9 | (Refused) | **(Continue)** |

_____(2510)

H2. **(If code 2, 8, or 9 in H1, ask:)** Are you paid in direct relation to the amount of time you work, such as by the shift or by the hour?
**SALTIME**

| | | |
|---|---|---|
| 1 | Yes - | **(Skip to H4)** |
| 2 | No | **(Skip to H4)** |
| 8 | (DK) | **(Skip to H4)** |
| 9 | (Refused) | **(Skip to H4)** |

_____(2511)

H3. **(If code 1 in H1, ask:)** Is your base salary a fixed amount that will not change until your salary is re-negotiated or is it adjusted up or down during the present contract period depending on your performance or that of the practice? **(If necessary, say:)** Adjusted up or down means for example, some practices pay their physicians an amount per month that is based on their expected revenue, but this amount is adjusted periodically to reflect actual revenue produced. **(INTERVIEWER NOTE: Base salary is the fixed amount of earnings, independent of bonuses or incentive payments.)**

**SALADJ**

1 Fixed amount
2 Adjusted up or down
8 (DK)
9 (Refused) _____(2512)

H4. Are you currently eligible to earn income through any type of bonus or incentive plan? **(INTERVIEWER NOTE: Bonus can include any type of payment above the fixed, guaranteed salary)**

**BONUS**

1 Yes - **(Skip to Note before H5)**

2 No **(Continue)**
8 (DK) **(Continue)**

9 (Refused) - **(Skip to Note before H5)** _____(2513)

H4a. **(If code 2 or 8 in H4, ask:)** Are you eligible to receive end-of-year adjustments, returns on withholds, or any type of supplemental payments, either from this practice or from health plans?

**SUPLPAY**

1 Yes
2 No
8 (DK)
9 (Refused) _____(3515)

**(If code 1 in H2 OR code 1 in H3, Continue; Otherwise, Skip to H7)**

H5. I am going to read you a short list of factors that are sometimes taken into account by medical practices when they determine the compensation paid to physicians in the practice. For each factor, please tell me whether or not it is EXPLICITLY considered: **(INTERVIEWER NOTE: "Practice" refers to main practice)**

[**(If code 1 in H1, AND code 2 or 8-9 in H4 AND H4a, ask:)** When your salary is determined, does the practice consider **(read A-E)**?

**(If code 1 in H1 AND code 1 in H4 OR H4a, ask:)** When either your base salary or bonus is determined, does the practice consider **(read A-E)**?

**(If code 1 in H2, AND code 2, 8, or 9 in H4 AND H4a, ask:)** When your pay rate is determined, does the practice consider **(read A-E)**?

**(If code 1 in H2, AND code 1 in H4 OR H4a, ask:)** When either your pay rate or bonus is determined, does the practice consider **(read A-E)**?

1 Yes
2 No
8 (DK)
9 (Refused)

**SPROD A**

A. Factors that reflect your own productivity **(If necessary, say:)** Examples include the amount of revenue you generate for the practice, the number of relative value units you produce, the number of patient visits you provide, or the size of your enrollee panel. _____(2514)

**SSAT A**

B. Results of satisfaction surveys COMPLETED BY YOUR OWN PATIENTS _____(2515)

**SQUAL A**

C. Specific measures of quality of care, such as rates of preventive care services for your patients _____(2516)

**SPROF A**

D. Results of practice profiling comparing your pattern of using medical resources to treat patients with that of other physicians **(INTERVIEWER NOTE: A practice profile is a report that is usually computer generated, which compares you to other physicians on things like referrals to specialists, hospitalizations, and other measures of cost effectiveness.)** _____(2517)

H5. (Continued:)

SPERF A

E. The overall financial performance of the practice **(INTERVIEWER NOTE: This item refers to the costs and revenues generated by all of the physicians in the practice)** _____(3516)

**(If code 2, 8, or 9 to ALL in H5 A-E, Skip to H15a; Otherwise, Skip to Note before H7a)**

**(Question H6 deleted)**

H7. **(If code 2, 8, or 9 in H2, or code 2, 8, or 9 in H3, ask:)** I am now going to read you a short list of factors that are sometimes taken into account by medical practices when they determine the compensation paid to physicians in the practice. For each factor, please tell me whether or not it is EXPLICITLY considered when your compensation is determined. Does the practice in which you work consider **(read A-E)**? **(INTERVIEWER NOTE: "Practice" refers to main practice)**

1 Yes
2 No
8 (DK)
9 (Refused)

SPROD B

A. Factors that reflect YOUR OWN productivity **(If necessary, say:)** Examples include the amount of revenue you generate for the practice, the number of relative value units you produce, the number of patient visits you provide, or the size of your enrollee panel. _____(2519)

SSAT B

B. Results of satisfaction surveys COMPLETED BY YOUR OWN PATIENTS _____(2520)

SQUAL B

C. Specific measures of quality of care, such as rates of preventive care services for your patients _____(2521)

SPROF B

D. Results of practice profiles comparing your pattern of using medical resources to treat patients with that of other physicians **(INTERVIEWER NOTE: A practice profile is a report that is usually computer generated, which compares you to other physicians on things like referrals to specialists, hospitalizations and other measures of cost effectiveness)** _____(2522)

H7. (Continued:)

**SPERF B**

E. The overall financial performance of the practice **(INTERVIEWER NOTE: This item refers to the costs and revenues generated by all of the physicians in the practice)** _____(3517)

**(If code 1 in H5-A or H7-A, H5-B or H7-B, H5-C or H7-C, H5-D or H7-D OR H5-E or H7-E, Continue; Otherwise, Skip to H15a)**

[Deleted CLOCK] HOLD _____(1645-1648)

H7a. For each of the factors you mentioned, tell me whether it is very important, moderately important, not very important, or not at all important in determining your compensation? How about **(read and rotate A-E, as appropriate)**?

4 Very important
3 Moderately important
2 Not very important
1 Not at all important

8 (DK)
9 (Refused)

**IMPPROD**

A. **(If code 1 in H5-A or H7-A, ask:)** Your own productivity _____(3518)

**IMPPSAT**

B. **(If code 1 in H5-B or H7-B, ask:)** Satisfaction surveys _____(3519)

**IMPQUAL**

C. **(If code 1 in H5-C or H7-C, ask:)** Quality of care measures _____(3520)

**IMPPROF**

D. **(If code 1 in H5-D or H7-D, ask:)** Results of practice profiling _____(3521)

**IMPRPRF**

E. **(If code 1 in H5-E or H7-E, ask:)** Overall practice performance _____(3522)

**(There are no questions H8-H12)**

[Deleted CLOCK] HOLD _____(1649-1652)

**(Questions H13 and H14 deleted)** HOLD _____(3523-3542)

H15a. During 2003, what was your own net income from the practice of medicine to the nearest $1,000, after expenses but before taxes? Please include contributions to retirement plans made for you by the practice and any bonuses as well as fees, salaries and retainers. Exclude investment income. Please include earnings from ALL practices, not just your main practice. **(If necessary, say:)** We define investment income as income from investments in medically related enterprises independent of a physician's medical practice(s), such as medical labs or imaging centers. **(If respondent refuses, say:)** This information is important to a complete understanding of community health care patterns and will be used only in aggregate form to ensure your confidentiality of the information. (Open ended **and code actual number)** **(If response is > $1 million, verify)**

**INCOME**

0000000-
9999999 **(Skip to H18)**

DK (DK) **(Continue)**
RF (Refused) **(Continue)**

_____ _____
_____ (2527 - 2533)

H15b. **(If code DK in H15a, ask:)** Would you say that it was **(read 01-04)**?

**(If code RF in H15a, ask:)** Would you be willing to indicate if it was **(read 01-04)**?

**INCCAT**

01 Less than $100,000
02 $100,000 to less than $150,000
03 $150,000 to less than $250,000
04 $250,000 or more

98 (DK)
99 (Refused)

_____ _____
_____ (2534) (2535)

[Deleted Note]

**(Questions H16 and H17 deleted)** HOLD _____(3543-3548)

H18. Do you consider yourself to be of Hispanic origin, such as Mexican, Puerto Rican, Cuban, or other Spanish background? **(Probe Refusals with:)** I understand this question may be sensitive. We are trying to understand how physicians from different ethnic and cultural backgrounds perceive some of the changes that are affecting the delivery of medical care.

**HISP**

1 Yes
2 No
8 (DK)
9 (Refused) _____(1659)

H19. What race do you consider yourself to be? **(If respondent hesitates, read 06-09)** **(Probe Refusals with:)** I understand this question may be sensitive. We are trying to understand how physicians from different ethnic and cultural backgrounds perceive some of the changes that are affecting the delivery of medical care.] (Open ended and code) **(INTERVIEWER NOTE: If respondent specifies a mixed race or a race not pre-coded, code as 01 - Other)**

**RACE**

01 Other (list)

02-
05 HOLD

06 White/Caucasian
07 African-American/Black
08 Native American (American Indian) or Alaska Native
09 Asian or Pacific Islander

98 (DK)
99 (Refused)

_____ _____
(1660) (1661)

_____

[Deleted CLOCK] HOLD _____(2637-2640)

H20. Finally, I am going to list several problems that may limit physicians' ability to provide high quality care. For each one, tell me whether it is a MAJOR PROBLEM, MINOR PROBLEM, OR NOT A PROBLEM affecting your ability to provide high quality care. How about **(read and rotate A-H, as appropriate)**?

3 Major problem
2 Minor problem
1 Not a problem

8 (DK)
9 (Refused)

**QNOTIME**
A. Inadequate time with patients during office visits _____(3549)

**QPRBPAY**
B. Patients' inability to pay for needed care _____(3550)

**QINSREJ**
C. Rejections of care decisions by insurance companies _____(3551)

**QNOSPEC**
D. Lack of qualified specialists in your area _____(3552)

**QNOREPT**
E. Not getting timely reports from other physicians and facilities _____(3553)

**QLANG**
F. Difficulties communicating with patients due to language or cultural barriers _____(3554)

**(Item G deleted)** HOLD _____(3555)

**QERRHSP**
H. Medical errors in hospitals _____(3556)

CLOCK:

_____ _____
_____ (2233 - 2236)

**(SURVENT NOTE: If code 2 in S6a, Autocode 2 in I0)**

I0. **(If code 1 in S6a, ask:)** Our records indicate that you have already received your $25 honorarium check. Did you receive the check?

**CHECK**

1 Yes
2 No
8 (DK)
9 (Refused) _____(3275)

## ***SECTION I***
## ***ENDING***

[Deleted Note]

I1. Let me verify that your name and address are **(read information from fone file/S4)**? **(ENTER ALL THAT ARE INCORRECT)** **(INTERVIEWER NOTE: Verify PRACTICE ADDRESS)**

*

1 First name is incorrect _____(2554)
2 Last name is incorrect
3 Address is incorrect
4 City is incorrect
5 State is incorrect
6 Zip code is incorrect
7 All information correct

FIRST NAME: **(Display from fone file)**

_____ _____
_____ (1801 - 1816)

LAST NAME: **(Display from fone file)**

_____ _____
_____ (1781 - 1800)

**CSTREET**

ADDRESS #1: **(Display from fone file)**

_____ _____
_____ (1841 - 1880)

**CSTRET2**

ADDRESS #2: **(Display from fone file)**

_____ _____
_____ (3013 - 3037)

**CCITY**

CITY: **(Display from fone file)**

_____ _____
_____ (2682 - 2694)

**CSTATE**

I1. (Continued:)

STATE: **(Display from fone file)**

_____ _____
(2707) (2708)

_____

**CZIP**

ZIP CODE: **(Display from fone file)**

_____ _____
(2709 - 2713)

_____

[Deleted Note]

**(Question I1a deleted)** HOLD _____(2554)

HOLD _____(1781-1816)

**(All in I1a, Skip to I4)**

**(There are no questions #I1a-#I2)**

I3. Is the address of the practice we have been talking about during this interview **(read 1-2)**?

**ADROKAY**

1 **(Address from fone file)** - **(Skip to Note before #I5)**

2 **(If code 3-6 in #I1, say:)** **(Address in #I1)** - **(Skip to Note before #I5)**

3 No/Neither - **(Continue)**

8 (DK) **(Skip to Note before #I5)**
9 (Refused) **(Skip to Note before #I5)** _____(1356)

I4. Will you please give me the address of the practice we have been talking about during this interview? (Open ended)

**PSTRET1**

STREET ADDRESS #1:

_____ _____
_____ (2732 - 2761)

**PSTRET2**

STREET ADDRESS #2:

_____ _____
_____ (3088 - 3118)

**PCITY**

CITY:

_____ _____
_____ (2762 - 2791)

**PSTATE**

STATE:

_____ _____
_____ (2787) (2788)

**PZIP**

ZIP:

_____ _____
_____ (2789 - 2793)

**(If code 08, 09, or 10 in C2, C3, or C3c, Continue; If code 1 or 2 in C3a, Continue; Otherwise, Skip to J4)**

I5. What is the name of the practice we have been talking about during this interview? Include the names of government clinics as eligible responses to this question. **(If necessary, say:)** This information will help us to better understand the nature of physician organizations in your region. (Open ended)

**PNAME**

00001 Other (list)
00002 HOLD
00003 HOLD
00004 No/Yes mind giving
00005 HOLD

99998 (DK)
99999 (Refused)

_____ _____
(2812 - 2816)

_____
[Deleted Note]

**(Question I5a-I5b deleted)**

**(If code 2 in S1c, Continue; Otherwise, Skip to J4)**

I6. Are you with the same medical practice that you were with in January, 2002, or have you changed practices since then? **(If respondent asks, say:)** We will consider you as being in the same practice if your practice changed addresses, clinics, offices, or partners, BUT kept the same parent organization. OR, if your old practice changed ownership; for example, if the practice was sold to an outside organization, but you stayed on under the new ownership. A new practice would be one where you terminated your relationship and joined a different one. **(If respondent has multiple practices and changed one but NOT all of them, say:)** We are interested in whether you are with the same main medical practice that you were with in January, 2002. By main practice, we mean the practice where you spend most of your time.

**PRACCHG**

1 Yes, same practice - **(Skip to J4)**

2 No, changed practice - **(Continue)**

8 (DK) **(Skip to J4)**
9 (Refused) **(Skip to J4)** _____(1666)

I7. **(If code 2 in I6, ask:)** In what month and year did you change medical practice? (Open ended **and code month and year)**

**MTH CHG**

MONTH:

01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December

13 (DK)
14 (Refused)

_____ _____
(1667) (1668)

_____

**YR CHG**

YEAR: **(SURVENT NOTE: Block all years expect those listed below)**

2002
2003
2004
2005

9998 (DK)
9999 (Refused)

_____ _____
(1669 - 1672)

_____

**(There are no questions #I8-#I9)**

CLOCK:

_____ _____
(2229 - 2232)

_____

## ***SECTION J***
## ***SWEEP-UP***

**(There are no questions J1-J3)**

J4. This concludes the survey unless you have any brief comment you would like to add. (Open ended)

**COMMENT**

0001 Other (list)
0002-
0003 HOLD
0004 No/Nothing
9998 (DK)
9999 (Refused)

_____ _____
_____ (2555 - 2558)

J5. INTERVIEWER CODE ONLY: **(INTERVIEWER NOTE: Do NOT offer to send study report to respondent. Encourage use of Center's Website, www.hschange.org, and encourage them to put their name on the Center's mailing list by using the Website. Respondents can receive electronic notices of the Center's research, including results of the physician survey when they become available, by signing up on the Center's Web site, www.hschange.org.)** Did respondent ask any of the following?

1 Yes
2 No

A. Center's Web site address so they can access it themselves _____(2820)

B. To be placed on the Center's mailing list _____(2821)

**(There is no Item C)** HOLD _____(2822)

J6. INTERVIEWER COMMENTS:

_____ _____
_____ (3118 - 3119)

CLOCK:

_____ _____
_____ ( - )

**(VALIDATE PHONE NUMBER AND THANK RESPONDENT BY SAYING:)**

Again, this is _____, with The Gallup Organization of _____. I would like to thank you for your time. Our mission is to "help people be heard" and your opinions are important to Gallup in accomplishing this.

**DESCRIPTIVE NAMES ONLY: NEED ACTUAL FONE FILE NAMES AND NUMBER OF COLUMNS!**

1. MEDICAL EDUCATION: **(Code from fone file)**

_____ _____
_____ ( - )

2. PHYSICIAN NAME: **(Code from fone file)**

_____ _____
_____ ( - )

3. GENDER: **(Code from fone file)** _____(294)

4. PREFERRED PROFESSIONAL MAILING ADDRESS: **(Code from fone file)**

_____ _____
_____ ( - )

5. GEOGRAPHIC CODES (STATE, COUNTY, ZIP, MSA, CENSUS REGION OR DIVISION): **(Code from fone file)**

_____ _____
_____ ( - )

6. BIRTH DATE: **(Code from fone file)**

_____ _____
_____ (182 - 189)

7. BIRTH PLACE: **(Code from fone file)**

_____ _____
_____ ( - )

8. CITIZENSHIP AND VISA: **(Code from fone file)**

_____ _____
_____ ( – )

9. LICENSURE DATE: **(Code from fone file)**

_____ _____
_____ ( – )

10. NATIONAL BOARD COMPLETION DATE: **(Code from fone file)**

_____ _____
_____ ( – )

11. MAJOR PROFESSIONAL ACTIVITY: **(Code from fone file)**

_____ _____
_____ ( – )

12. PRIMARY SPECIALTY: **(Code from fone file)**

_____ _____
_____ ( – )

13. SECONDARY SPECIALTY: **(Code from fone file)**

_____ _____
_____ ( – )

14. PRESENT EMPLOYMENT: **(Code from fone file)**

_____ _____
_____ ( – )

15. AMERICAN SPECIALTY BOARD CERTIFICATION: **(Code from fone file)**

_____ _____
_____ ( – )

16. CURRENT AND FORMER MEDICAL TRAINING - (INSTITUTION, SPECIALTY, TRAINING DATES): **(Code from fone file)**

_____ _____
_____ ( – )

17. CURRENT AND FORMER GOVERNMENT SERVICE: **(Code from fone file)**

_____ _____
_____ ( - )

18. ECFMG CERTIFICATE: **(Code from fone file)**

_____ _____
_____ ( - )

19. TYPE OF PRACTICE: **(Code from fone file)**

_____ _____
_____ ( - )

20. TELEPHONE NUMBER: **(Code from fone file)**

_____ _____
_____ ( - )

21. FAX NUMBER: **(Code from fone file)**

_____ _____
_____ ( - )

INTERVIEWER I.D. #: _____(571-574)

**REVISIONS**

| | | |
|---|---|---|
| **6/14/04** | **Added:** | **Interviewer Note to I1, Note before I5a, I5a, I5b** |
| | **Revised:** | **Note after I4** |
| **7/2/04** | **Revised:** | **Wording in D2aa** |
| **7/13/04** | **Deleted:** | **Note before I1, Note after I1, I1a, Note after I1a, Note before I5a, I5a, I5b** |
| | **Revised:** | **Note after I4** |
| **9/2/04** | **Added:** | **Interviewer Note to B2** |

jlw\2004\RWJ\RWJ physician R4 0407

# Appendix B

# List of Variables in CTS Physician Survey Public Use and Restricted Use Data Files by Year

# CTS Physician Survey
## Survey Administration

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| PHYSIDX | CV | Physician identification number | yes | yes | yes | yes | yes | yes | yes | yes |
| R1PHYIDX | CV | Physician identification number in 1996-97 (Round 1) data file | | | | yes | | | | |
| R2PHYIDX | CV | Physician identification number in 1998-99 (Round 2) data file | | | | | | yes | | |
| R3PHYIDX | CV | Physician identification number in 2000-01 (Round 3) data file | | | | | | | | yes |
| SITEID | CV | Site identification number | | yes | | yes | | yes | | yes |
| MSACAT | CV | Large metro or small metro or non-metro site | | yes | | yes | | yes | | yes |
| FIPS | CV | State and county FIPS code | | yes | | yes | | yes | | yes |
| SUBGRP | CV | Sample (site vs supp.) and whether practice is in any site | | yes | | yes | | yes | | |
| PRACLOC | CV | Practice location in any CTS site | | | | | | | | yes |
| IMGSTAT | AMA/AOA | Country of medical school (US, Canada, Puerto Rico, other) | | yes | | yes | | yes | | yes |
| IMGUSPR | AMA/AOA | Medical school not in US or Puerto Rico | yes | yes | yes | yes | yes | yes | yes | yes |
| AMAPRIM | AMA/AOA | Whether primary care physician (PCP) | | yes | | yes | | yes | | yes |
| DOCTYP | AMA/AOA | DO or MD | | yes | | yes | | yes | | yes |
| GENDER | AMA/AOA | Gender | yes | yes | yes | yes | yes | yes | yes | yes |
| BIRTHX | AMA/AOA | Year of birth | yes | BIRTH | yes | BIRTH | yes | BIRTH | yes | BIRTH |
| GRADYRX | AMA/AOA | Year of graduation from medical school | yes | GRAD_YR | yes | GRAD_YR | yes | GRAD_YR | yes | GRAD_YR |

## CTS Physician Survey
## Section A: Basic Practice Information / Specialty and Certification / Career Satisfaction

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| MULTPR | A4 | Multiple practices | yes | yes | yes | yes | yes | yes | | |
| NUMPRX | A4a | Number of practices | yes | NUMPR | yes | NUMPR | yes | NUMPR | | |
| YRBGNX | A6 | Year began practicing medicine | yes | YRBGN | yes | YRBGN | yes | YRBGN | yes | YRBGN |
| NWSPEC | A8 | Primary specialty | | yes | | yes | | yes | | yes |
| GENSUB | A9 | Spec = general internal or general pediatric: time in primary spec vs subspec | | yes | | yes | | yes | | yes |
| SIPNPED | A9a | Spec = non-pediatric: time in primary spec vs general internal | | yes | | yes | | yes | | yes |
| SIPPED | A9b | Spec = pediatric: time in primary spec vs general pediatric | | yes | | yes | | yes | | yes |
| SUBSPC | A10 | Subspecialty | | yes | | yes | | yes | | yes |
| PCPFLAG | CV | Questionnaire definition of PCP | yes | yes | yes | yes | yes | yes | yes | yes |
| SPECX | CV | Seven-category specialty type | yes | yes | yes | yes | yes | yes | yes | yes |
| BDCERT | CV | Board certification status (certified, eligible, neither) | yes | yes | yes | yes | yes | yes | | |
| BDCTANY | CV | Board certified in any specialty | | | | | | | yes | yes |
| BDCTPS | CV | Board certified in primary (sub)specialty | yes | yes | yes | yes | | yes | yes | yes |
| BDELPS | CV | Board eligible in primary (sub)specialty | yes | yes | yes | yes | | yes | | |
| CARSAT | A19 | Overall career satisfaction | yes | yes | yes | yes | yes | yes | yes | yes |

## CTS Physician Survey

### Section B: Physician Time Allocation / Medical Information Obtained by Patients

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| WKSWRKX | B1 | Weeks practiced medicine in previous year | yes | WKSWRK, WKSWRKC | yes | WKSWRK, WKSWRKC | yes | WKSWRK, WKSWRKC | yes | WKSWRK, WKSWRKC |
| HRSMEDX | CV | Hours in medical activities in previous week | yes | HRSMED | yes | HRSMED | yes | HRSMED | yes | HRSMED |
| HRSPATX | CV | Hours in direct patient care activities in previous week | yes | HRSPAT | yes | HRSPAT | yes | HRSPAT | yes | HRSPAT |
| OFFICEVX | B5a | Number of patient visits in the office last week | | | | | | | yes | OFFICEV |
| OUTPTVX | B5b | Number of patient visits in outpatient clinics last week | | | | | | | yes | OUTPTV |
| NURSHMVX | B5c | Number of patient visits in nursing homes last week | | | | | | | yes | NURSHMV |
| HOSPVX | B5d | Number of patient visits on hospital rounds last week | | | | | | | yes | HOSPV |
| HRFREEX | B6 | Hours providing charity care in previous month | yes | HRFREE | yes | HRFREE | yes | HRFREE | yes | HRFREE |
| LOCFREE | B6a | Location of charity care | | | | | | | yes | yes |
| PPATMN | CV | Percent patient care time in main practice | yes | yes | | | | | | |
| PATINFO | B7 | Medical info obtained by patients: percent of patients | | | | | yes | yes | | |
| PATACT | B9 | Medical info obtained by patients: ordering tests, etc. | | | | | yes | yes | | |
| EFINFO | B10 | Medical info obtained by patients: effect on quality | | | | | yes | yes | | |
| EFEFF | B11 | Medical info obtained by patients: effect on efficiency | | | | | yes | yes | | |
| CHRNPT | B12 | Percent of patients with chronic medical conditions | | | | | | | yes | yes |
| ASIAPTX | B14 | Percent of patients that are Asian or Pacific Islander | | | | | | | yes | ASIAPT |
| BLCKPTX | B14 | Percent of patients that are African American or Black | | | | | | | yes | BLCKPT |
| HISPPTX | B14 | Percent of patients that are Hispanic or Latino | | | | | | | yes | HISPPT |
| LANGPTX | B15 | Percent of patients with language differences | | | | | | | yes | LANGPT |

## CTS Physician Survey
## Section C: Practice Arrangements and Ownership / Priorities Within Practice

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| OWNPR | C1 | Full owner or part owner or not an owner of (main) practice | yes | yes | yes | yes | yes | yes | yes | yes |
| TOPOWN | C2 | Type of practice (full and part owners) | | yes | | yes | | yes | | yes |
| TOPOWNX | CV | Type of practice (full and part owners), with C9 recodes | yes | TOPOWNC | yes | TOPOWNC | yes | TOPOWNC | yes | TOPOWNC |
| TOPEMP | C3 | Type of employer (non-owners) | | yes | | yes | | yes | | yes |
| TOPEMPC | CV | Type of employer (non-owners), with C9 recodes | | yes | | yes | | yes | | yes |
| TOPEMPX | CV | Type of employer (non-owners), with C9, C3b, and verbatim recodes | yes | TOPEMPA | yes | TOPEMPA | yes | TOPEMPA | yes | .TOPEMPA |
| FOSP | CV | Full owner of solo practice | | | | | | | yes | yes |
| PRCTYPE | CV | Practice type, 6 categories | yes | yes | yes | yes | yes | yes | yes | yes |
| ALLPRTP | CV | Practice type, detailed categories | | yes | | yes | | yes | | yes |
| OTHSET | C3a | For gov employees: hospital or clinic or other | | yes | | yes | | yes | | yes |
| EMPTYP | C3b | Type of employer (non-owners), other | | yes | | yes | | yes | | yes |
| EMPTYP2 | C3c | Type of employer (non-owners), other | | | | yes | | yes | | yes |
| GRTYPEX | CV | Type of group practice | | | yes | GRTYPE | yes | GRTYPE | yes | GRTYPE |
| OTHPAR | C4 | Owned (full or part) by other physician(s) in practice | yes | yes | yes | yes | yes | yes | | |
| OTHGRP | C5A | Owned (full or part) by different physician practice | | yes | | yes | | yes | | |
| HSPPAR | C5B | Owned (full or part) by hospital | | yes | | yes | | yes | | |
| INSPAR | C5C | Owned (full or part) by insurance co or HMO | | yes | | yes | | yes | | |
| ORGPAR | C5D | Owned (full or part) by other organization | | yes | | yes | | yes | | |
| C5OWNX | CV | Any outside ownership of practice | yes | C5OWNER | yes | C5OWNER | yes | C5OWNER | | |
| ORGC_1 | CV | Owner org is other | | yes | | yes | | yes | | |
| ORGC_2 | CV | Owner org is not known | | yes | | yes | | yes | | |
| ORGC_6 | CV | Owner org is integrated health system | | yes | | yes | | yes | | |
| ORGC_7 | CV | Owner org is physician practice management | | yes | | yes | | yes | | |
| ORGC_8 | CV | Owner org is management services organization | | yes | | yes | | yes | | |
| ORGC_9 | CV | Owner org is physician hospital org | | yes | | yes | | yes | | |
| ORGC_10 | CV | Owner org is university or medical school | | yes | | yes | | yes | | |
| ORGC_11 | CV | Owner org is medical foundation | | yes | | yes | | yes | | |

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| ORGC_12 | CV | Owner org is other non-profit | | yes | | yes | | yes | | |
| ORGC_13 | CV | Owner org is other physicians in practice | | | | yes | | yes | | |
| ORGC_14 | CV | Owner org is another physician group | | | | yes | | yes | | |
| ORGC_15 | CV | Owner org is hospital | | | | yes | | yes | | |
| ORGC_16 | CV | Owner org is insurance co or HMO | | | | yes | | yes | | |
| SETTING | C6b | Setting for seeing patients (if in medical school or hospital) | | | | | | yes | | yes |
| NPHYSX | C7 | Number of physicians in practice | yes | NPHYS | yes | NPHYS | yes | NPHYS | yes | NPHYS |
| NASSISX | C8 | Number of medical assistants in practice | yes | NASSIST | yes | NASSIST | | | | |
| NURSLEV | C8a | Level of nursing support | | | | | | | yes | yes |
| WHYNRSL | C8aa | Reason for worse level of nursing support | | | | | | | yes | yes |
| ACQUIRD | C10 | Practice purchased in last 2 yrs | yes | yes | yes | yes | yes | yes | | |
| OWNPURX | C11 | Ownership when practice purchased | yes | OWNPUR | yes | OWNPUR | yes | OWNPUR | | |
| CTL_WRK | C12A | Importance of control over working hours | | | | | yes | yes | | |
| CTL_DEC | C12B | Importance of control over clinical decisions | | | | | yes | yes | | |
| CTL_INC | C12C | Importance of potential income | | | | | yes | yes | | |
| CTL_BUS | C12D | Importance of control over practice's business decisions | | | | | yes | yes | | |

## CTS Physician Survey

### Section D: Computer Use / Medical Care Management Strategies / Gatekeeping / Scope of Care

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| EFDATA | D1A | Effect of computers on obtaining or recording clinical data | yes | yes | yes | yes | | | | |
| EFTREAT | D1B | Effect of computers on obtaining information about treatments | yes | yes | yes | yes | | | | |
| EFRMNDR | D1C | Effect of preventive service reminders | yes | yes | yes | yes | | | | |
| EFGUIDE | D1D (D4A in 2000-01) | Effect of formal written practice guidelines | yes | yes | yes | yes | yes | yes | yes | yes |
| EFPROFL | D1E (D4B in 2000-01) | Effect of practice profiles | yes | yes | yes | yes | yes | yes | | |
| EFSURV | D1F (D4C in 2000-01) | Effect of patient satisfaction surveys | yes | yes | yes | yes | yes | yes | | |
| IT_TRT | D1A in 2000-01 | Use of computers to obtain information on treatments | | | | | yes | yes | yes | yes |
| IT_FORM | D1B in 2000-01 | Use of computers to obtain information on formularies | | | | | yes | yes | yes | yes |
| ITRMNDR | D1C in 2000-01 | Use of computers for reminders about preventive services | | | | | yes | yes | yes | yes |
| ITNOTES | D1D in 2000-01 | Use of computers to access patient notes etc. | | | | | yes | yes | yes | yes |
| ITPRESC | D1E in 2000-01 | Use of computers to write prescriptions | | | | | yes | yes | yes | yes |
| ITCLIN | D1F in 2000-01 | Use of computers for clinical data exchanges with other physicians | | | | | yes | yes | yes | yes |
| ITHOSP | D1F1 | Use of computers for clinical data and image exchanges w/labs etc | | | | | | | yes | yes |
| ITCOMM | D1G in 2000-01 | Use of computers to communicate with patients by email | | | | | yes | yes | yes | yes |
| ITDRUG | D1H | Use of computers for info on drug interactions | | | | | | | yes | yes |
| ACC_INT | D2 | Internet access at workplace | | | | | yes | yes | | |
| EPRESC | D2aa | Percentage of prescriptions written electronically | | | | | | | yes | yes |
| FORMLRY | D3 | Patients with prescription coverage that includes formulary | | | | | yes | yes | yes | yes |
| AWRGUID | D4A1 | Awareness of formal written guidelines | | | | | yes | yes | yes | yes |
| AWRPROF | D4B1 | Awareness of practice profiling | | | | | yes | yes | | |
| AWRSURV | D4C1 | Awareness of patient satisfaction surveys | | | | | yes | yes | | |
| QU_FRMY | D5B | Effect on efficiency and quality of care: formularies | | | | | yes | yes | | |
| QUGUIDE | D5C | Effect on efficiency and quality of care: practice guidelines | | | | | yes | yes | | |
| QUPROF | D5D | Effect on efficiency and quality of care: practice profiles | | | | | yes | yes | | |
| QUSURV | D5E | Effect on efficiency and quality of care: patient satisfaction surveys | | | | | yes | yes | | |

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| CPOEHSP | D6 | Hospital has computerized system to order tests and medications | | | | | | | yes | yes |
| ERRREPT | D6 | Hospital has computerized system to report medical errors | | | | | | | yes | yes |
| HSPLST | D7 | Percent of hospitalized patients who had hospitalist | | | | | | | yes | yes |
| CMPPROV | D7 | PCPs: change in complexity/severity without referral | yes | yes | yes | yes | yes | yes | | |
| CMPEXPC | D8 | PCPs: appropriateness of care required without referral | yes | yes | yes | yes | yes | yes | yes | yes |
| SPECUSE | D9 | PCPs: change in number of referrals to specialists | yes | yes | yes | yes | yes | yes | yes | yes |
| PCTGATE | D10 | PCPs: percent of patients for whom gatekeeper | yes | yes | yes | yes | yes | yes | yes | yes |
| CMPCHG | D11 | Spec: change in complexity/severity when referred | yes | yes | yes | yes | yes | yes | | |
| CMPLVL | D12 | Spec: appropriateness at referral | yes | yes | yes | yes | yes | yes | | |
| CHGREF | D13 | Spec: change in number of referrals from PCPs | yes | yes | yes | yes | yes | yes | | |

## Section E: Practice Styles of Primary Care Physicians

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| WHOCARE | EA | Practice provides care to adults and/or kids | yes | yes | yes | yes | | | | |
| FORM | EA | Which vignette questions were asked | yes | yes | yes | yes | | | | |
| VCHOL | E1 | Pct oral agents for elevated cholesterol | yes | yes | yes | yes | | | | |
| VCHOLF | E1a | Freq oral agents for elevated cholesterol | yes | yes | yes | yes | | | | |
| VHYPER | E3 | Pct urology referral for prostatic hyperplasia | yes | yes | yes | yes | | | | |
| VHYPERF | E3a | Freq urology referral for prostatic hyperplasis | yes | yes | yes | yes | | | | |
| VCHEST | E4 | Pct cardiology referral for chest pain | yes | yes | yes | yes | | | | |
| VCHESTF | E4a | Freq cardiology referral for chest pain | yes | yes | yes | yes | | | | |
| VBACK | E5 | Pct MRI for low back pain | yes | yes | yes | yes | | | | |
| VBACKF | E5a | Freq MRI for low back pain | yes | yes | yes | yes | | | | |
| V60MAN | E9 | Pct PSA test for 60 year old male | yes | yes | yes | yes | | | | |
| V60MANF | E9a | Freq PSA test for 60 year old male | yes | yes | yes | yes | | | | |
| VVITCH | E10 | Pct office visit for vaginal itching | yes | yes | yes | yes | | | | |
| VVITCHF | E10a | Freq office visit for vaginal itching | yes | yes | yes | yes | | | | |
| VENUR | E11 | Pct DDAVP for child with enuresis | yes | yes | yes | yes | | | | |
| VENURF | E11a | Freq DDAVP for child with enuresis | yes | yes | yes | yes | | | | |
| VTHRT | E16 | Pct office visit for fever sore throat child | yes | yes | yes | yes | | | | |
| VTHRTF | E16a | Freq office visit for fever sore throat child | yes | yes | yes | yes | | | | |
| VCOUGH | E17 | Pct x-ray for fever tachypnea child | yes | yes | yes | yes | | | | |
| VCOUGHF | E17 | Freq x-ray for fever tachypnea child | yes | yes | yes | yes | | | | |
| VSUPOT | E18 | Pct ENT referral for suppurative otitis media child | yes | yes | yes | yes | | | | |
| VSUPOTF | E18a | Freq ENT referral for suppurative otitis media child | yes | yes | yes | yes | | | | |
| V6FEVR | E20 | Pct sepsis workup for fever 6 wk old child | yes | yes | yes | yes | | | | |
| V6FEVRF | E20a | Freq sepsis workup for fever 6 wk old child | yes | yes | yes | yes | | | | |
| VECZEM | E21 | Pct allergist referral for eczema asthma child | yes | yes | yes | yes | | | | |
| VECZEMF | E21a | Freq allergist referral for eczema asthma child | yes | yes | yes | yes | | | | |

## CTS Physician Survey
## Section F: Ability to Provide Care / Ability to Obtain Needed Services for Patients / Acceptance of New Patients

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| ADQTIME | CV | Adequate time to spend with patients during typical office visit | yes | yes | yes | yes | yes | yes | | |
| CLNFREE | F1C | Freedom to make clinical decisions in patients' best interest | yes | yes | yes | yes | yes | yes | | |
| HIGHCAR | F1D | Possible to provide high quality care to all patients | yes | yes | yes | yes | yes | yes | | |
| NEGINCN | F1E | Can make clinical decisions without negative effect on income | yes | yes | yes | yes | yes | yes | | |
| RADQTIME | CV | Adequate time to spend with patients during typical office visit | | | | | | | yes | yes |
| RCLNFREE | F1C | Freedom to make clinical decisions in patients' best interest | | | | | | | yes | yes |
| RHIGHCAR | F1D | Possible to provide high quality care to all patients | | | | | | | yes | yes |
| RNEGINCN | F1E | Can make clinical decisions without negative effect on income | | | | | | | yes | yes |
| USESPCS | F1F | Sufficient communication with specialists | yes | yes | yes | yes | yes | yes | | |
| COMPRM | F1G | Sufficient communication with primary care physicians | yes | yes | yes | yes | yes | yes | | |
| COMMALL | CV | Sufficient communication with other physicians to ensure high quality care | yes | yes | yes | yes | yes | yes | | |
| PATREL | F1H | Possible to maintain continuing patient relationships | yes | yes | yes | yes | yes | yes | | |
| RPATREL | F1H | Possible to maintain continuing patient relationships | | | | | | | yes | yes |
| OBREFS | F8A | Obtaining referrals to high quality specialists | yes | yes | yes | yes | yes | yes | | |
| OBANCL | F8B | Obtaining high quality ancillary services | yes | yes | yes | yes | yes | yes | | |
| OBHOSP | F8C | Obtaining non-emergency hospital admission | yes | yes | yes | yes | yes | yes | | |
| OBINPAT | F8D | Obtaining adequate number inpatient days | yes | yes | yes | yes | yes | yes | | |
| OBIMAG | F8E | Obtaining high quality diagnostic imaging | yes | yes | yes | yes | yes | yes | | |
| OBMENTL | F8F | Obtaining high quality inpatient mental health care | yes | yes | yes | yes | yes | yes | | |
| OBOUTPT | F8G | Obtaining high quality outpatient mental health care | yes | yes | yes | yes | yes | yes | | |
| REFPROV | F8aAa | Referral difficulties: not enough providers | | | | | yes | yes | | |
| REFHP | F8aAb | Referral difficulties: health plan limitations | | | | | yes | yes | | |
| REFINS | F8aAc | Referral difficulties: patient has inadequate insurance | | | | | yes | yes | | |
| HSPPROV | F8aCa | Hospital admission difficulties: not enough providers | | | | | yes | yes | | |
| HSPHP | F8aCb | Hospital admission difficulties: health plan limitations | | | | | yes | yes | | |
| HSPINS | F8aCc | Hospital admission difficulties: patient has inadequate insurance | | | | | yes | yes | | |

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| MHPROV | F8aGa | Outpatient mental health care difficulties: not enough providers | | | | | yes | yes | | |
| MHHP | F8aGb | Outpatient mental health care difficulties: health plan limitations | | | | | yes | yes | | |
| MHINS | F8aGc | Outpatient mental health care difficulties: patient has inadequate insurance | | | | | yes | yes | | |
| NOTREFS | F8bA | Unable to get referrals to high-quality specialists | | | | | | | yes | yes |
| NOTHOSP | F8bC | Unable to get non-emergency hospital admissions | | | | | | | yes | yes |
| NOTIMAG | F8bD | Unable to get high-quality diagnostic imaging services | | | | | | | yes | yes |
| NOTOUTP | F8bE | Unable to get high-quality outpatient mental health services | | | | | | | yes | yes |
| REFPRVR | F8cAa | Importance of reason unable to get referrals: not enough providers/facilities | | | | | | | yes | yes |
| REFHPR | F8cAb | Importance of reason unable to get referrals: network/admin barriers | | | | | | | yes | yes |
| REFINSR | F8cAc | Importance of reason unable to get referrals: lack/inadequate patient health plan coverage | | | | | | | yes | yes |
| HSPPRVR | F8cBa | Importance of reason unable to get hospital admission: not enough providers/facilities | | | | | | | yes | yes |
| HSPHPR | F8cBb | Importance of reason unable to get hospital admission: network/admin barriers | | | | | | | yes | yes |
| HSPINSR | F8cBc | Importance of reason unable to get hospital admission: lack/inadequate patient health plan coverage | | | | | | | yes | yes |
| MHPROVR | F8cCa | Importance of reason unable to get mental health services: not enough providers/facilities | | | | | | | yes | yes |
| MHHPR | F8cCb | Importance of reason unable to get mental health services: network/admin barriers | | | | | | | yes | yes |
| MHINSR | F8cCc | Importance of reason unable to get mental health services: lack/inadequate patient health plan coverage | | | | | | | yes | yes |
| GENERIC | F8dA | Prescribe generic over brand name drug | | | | | | | yes | yes |
| DIAGCST | F8dB | Consider patient's out-of-pocket costs when deciding tests | | | | | | | yes | yes |
| IOPTCST | F8dC | Consider patient's out-of-pocket costs for inpatient/outpatient care | | | | | | | yes | yes |
| NWMCARE | F9A | Practice accepts new Medicare patients | yes | yes | yes | yes | yes | yes | yes | yes |
| NWMCAID | F9B | Practice accepts new Medicaid patients | yes | yes | yes | yes | yes | yes | yes | yes |
| NWPRIV | F9C | Practice accepts new privately insured patients | yes | yes | yes | yes | yes | yes | yes | yes |
| NWNPAY | F9G | Practice accepts new uninsured patients unable to pay | | | | | yes | yes | yes | yes |

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| ACC_CAP | F10 | Practice accepts new patients under capitated contracts | | | | | yes | yes | | |
| MRBILL | F11A | Reason no new Medicare patients: Billing requirements | | | | | | | yes | yes |
| MRAUDIT | F11B | Reason no new Medicare patients: Audit concern | | | | | | | yes | yes |
| MRREIMB | F11C | Reason no new Medicare patients: Inadequate reimbursement | | | | | | | yes | yes |
| MRNUFPT | F11D | Reason no new Medicare patients: Already enough patients | | | | | | | yes | yes |
| MRPTBUR | F11E | Reason no new Medicare patients: Patients have high clinical burden | | | | | | | yes | yes |
| MDBILL | F12A | Reason no new Medicaid patients: Billing requirements | | | | | | | yes | yes |
| MDDELAY | F12B | Reason no new Medicaid patients: Delayed reimbursement | | | | | | | yes | yes |
| MDREIMB | F12C | Reason no new Medicaid patients: Inadequate reimbursement | | | | | | | yes | yes |
| MDNUFPT | F12D | Reason no new Medicaid patients: Already enough patients | | | | | | | yes | yes |
| MDPTBUR | F12E | Reason no new Medicaid patients: Patients have high clinical burden | | | | | | | yes | yes |

# CTS Physician Survey
## Section G: Practice Revenue

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| PMCARE | G1A | Percent of practice revenue from Medicare | yes | yes | yes | yes | yes | yes | yes | yes |
| PMCAID | G1B | Percent of practice revenue from Medicaid or other public ins. | yes | yes | yes | yes | yes | yes | yes | yes |
| CAPAMTC | CV | Capitated/prepaid revenue from largest managed care contract | yes | yes | yes | yes | | | | |
| PCAPREV | CV | Percent of practice revenue that is capitated/prepaid | yes | yes | yes | yes | yes | yes | yes | yes |
| NMCCONX | CV | Number of managed care contracts | yes | NMCCON | yes | NMCCON | yes | NMCCON | yes | NMCCON |
| PMC | CV | Percent of practice revenue from managed care | yes | yes | yes | yes | yes | yes | yes | yes |
| PBIGCON | CV | Percent of practice revenue from largest managed care contract | yes | yes | yes | yes | | | | |

# CTS Physician Survey
## Section H: Physician Compensation and Race/Ethnicity

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| SALPAID | H1 | Salaried physician | yes | yes | yes | yes | yes | yes | yes | yes |
| SALTIME | H2 | Compensation directly related to time worked | yes | yes | yes | yes | yes | yes | yes | yes |
| SALADJ | H3 | Base salary fixed or adjustable | yes | yes | yes | yes | yes | yes | yes | yes |
| BONUS | H4 | Current inc: eligible for bonus or other performance incentives | yes | yes | yes | yes | yes | yes | | |
| BONUSR | H4 | Current inc: eligible for bonus or other performance incentives | | | | | | | yes | yes |
| SUPLPAY | H4 | Eligible for end-of-year adjustments/supplemental pay | | | | | | | yes | yes |
| ELINCENT | H4 | Eligible for bonuses | | | | | | | yes | yes |
| SPROD | CV | Own productivity affects compensation | yes | yes | yes | yes | yes | yes | yes | yes |
| SSAT | CV | Patient satisfaction affects compensation | yes | yes | yes | yes | yes | yes | yes | yes |
| SQUAL | CV | Quality measures affect compensation | yes | yes | yes | yes | yes | yes | yes | yes |
| SPROF | CV | Profiling results affect compensation | yes | yes | yes | yes | yes | yes | yes | yes |
| SPERF | CV | Overall financial performance of practice affects compensation | | | | | | | yes | yes |
| IMPROD | H7aA | Importance of own productivity in determinings compensation | | | | | | | yes | yes |
| IMPPSAT | H7aB | Importance of results of satisfaction surveys in determining compensation | | | | | | | yes | yes |
| IMPQUAL | H7aC | Importance of quality of care measures in determining compensation | | | | | | | yes | yes |
| IMPPROF | H7aD | Importance of results of practice profiling in determining compensation | | | | | | | yes | yes |
| IMPRPRF | H7aE | Importance of results of overall practice performance in determining compensation | | | | | | | yes | yes |
| RADJ | CV | Profiles are risk adjusted | yes | yes | yes | yes | yes | yes | | |
| PCTINCN | H9 | Previous inc: % from bonus or other performance incentives | | yes | | yes | | yes | | |
| PCTINCX | CV | Previous inc: % from bonus or other performance incentives, edited and imputed | yes | PCTINCC | yes | PCTINCC | yes | PCTINCC | | |
| EBONUS | H9a | Previous inc: eligible for bonus or other performance incentives | yes | yes | yes | yes | yes | yes | | |
| INCOMEX | H10 | Previous inc: net income from practice of medicine | yes | INCOMET | yes | INCOMET | yes | INCOMET | yes | INCOMET |
| INCENT | H10b/CX | Influence of financial incentives on services | | | | | yes | yes | yes | yes |
| EFINCNT | H10b1 | Influence of financial incentives on services | | | | | yes | yes | yes | yes |

| Variable name | Question number | Description | 1996-97 | | 1998-99 | | 2000-01 | | 2004-05 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use | Public Use | Restr. Use |
| FININCPT | CV | Influence of financial incentives on services | | | | | yes | yes | yes | yes |
| COMPETE | H10c | Competitive situation that practice faces | | | | | yes | yes | yes | yes |
| HISP | H11 | Respondent is of Hispanic origin | | | | yes | | yes | | yes |
| RACEX | H12 | Respondent race | | | yes | RACE | yes | RACE | yes | RACE |
| QNOTIME | H20A | Problem providing high-quality care: Inadequate time w/patient | | | | | | | yes | yes |
| QPRBPAY | H20B | Problem providing high-quality care: Patient unable to pay | | | | | | | yes | yes |
| QINSREJ | H20C | Problem providing high-quality care: Insurance co. rejects care decision | | | | | | | yes | yes |
| QNOSPEC | H20D | Problem providing high-quality care: Lack of qualified specialists | | | | | | | yes | yes |
| QNOREPT | H20E | Problem providing high-quality care: Not getting timely reports | | | | | | | yes | yes |
| QLANG | H20F | Problem providing high-quality care: Language/cultural barriers | | | | | | | yes | yes |
| QERRHSP | H20H | Problem providing high-quality care: Medical errors in hospitals | | | | | | | yes | yes |

# Appendix C

# Site Selection for the Community Tracking Study

# APPENDIX C

# SITE SELECTION FOR THE COMMUNITY TRACKING STUDY

For the first three rounds of the CTS Physician Survey, the survey used a two-tiered sample design that made it possible to develop estimates at the national and community (site) levels.

- The first tier was 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 was large enough to support estimates in each site.
- The second tier was a sample from 48 communities, in each of which a smaller sample of physicians were surveyed. This sample of "low-intensity" sites allowed us to validate results from the high-intensity sites and permits findings to be generalized to the nation. The first and second tiers together were known as the *site sample*.

Interviews were administered to physicians in the 60 CTS sample sites and to an independent national sample of households, referred to as the "national supplement." To reduce the cost of the Round Four 2004-05 Physician Survey, the national supplement was eliminated. In addition, in Round Four the 12 "high intensity" sites were not oversampled as they had been previously. In addition, the sample allocation was adjusted to achieve approximately equal samples of primary care providers and specialists. Otherwise, the design of the 2004-05 sample was similar to prior rounds, retaining a nationally representative 60-site sample design.

The following paragraphs describe how the sites were selected using terminology (e.g., site sample) from the original sampling design. Although the sampling was changed in the Round Four as described above, the 60 sites in Round Four are the same as those used in the previous rounds of the survey.

## 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.

### 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) at the beginning of the CTS.[1]

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

## 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. Physicians from 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.

## 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 codes, 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.[2]

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