2017 Physician Re-Licensure Survey Instrument

1. What is your employment status?
   RADIO BUTTONS
   a. Actively working in a position that requires a medical license
   b. Actively working in a field other than medicine
   c. Not currently working
   d. Retired

2. What is your race? Mark one or more boxes.
   MULTI CHECK BOX
   a. White
   b. American Indian or Alaska Native
   c. Native Hawaiian/Pacific Islander
   d. Black or African American
   e. Asian
   f. Some Other Race

3. Are you of Hispanic or Latino origin?
   RADIO BUTTONS
   a. Yes
   b. No

4. Where did you complete your medical degree?
   DROP-DOWN LIST
   a. Indiana
   b. Michigan
   c. Illinois
   d. Kentucky
   e. Ohio
   f. Another State (not listed)
   g. Another Country (not U.S.)

5. Where did you complete your residency training?
   DROP-DOWN LIST
   a. Indiana
   b. Michigan
   c. Illinois
   d. Kentucky
   e. Ohio
   f. Another State (not listed)
   g. Another Country (not U.S.)
6. Which of the following best describes the area of practice in which you spend most of your professional time? Please select only one response.

DROP-DOWN LIST

a. Adolescent Medicine
b. Anesthesiology
c. Allergy and Immunology
d. Cardiology
e. Child Psychiatry
f. Colon and Rectal Surgery
g. Critical Care Medicine
h. Dermatology
i. Endocrinology
j. Emergency Medicine
k. Family Medicine/General Practice
l. Gastroenterology
m. Geriatric Medicine
n. Gynecology Only
o. Hematology & Oncology
p. Infectious Diseases
q. Internal Medicine (General)
r. Nephrology
s. Neurological surgery
t. Neurology
u. Obstetrics and Gynecology
v. Occupational Medicine
w. Ophthalmology
x. Orthopedic Surgery
y. Other Surgical Specialties
z. Otolaryngology
aa. Pathology
bb. Pediatrics (General)
cc. Pediatrics Subspecialties
dd. Physical Medicine and Rehabilitation
e. Plastic Surgery
ff. Preventive Medicine/Public Health
gg. Psychiatry
hh. Pulmonology
ii. Radiation Oncology
jj. Radiology
kk. Rheumatology
ll. Surgery (General)
m. Thoracic Surgery
nn. Urology
oo. Vascular Surgery
pp. Other Specialties

7. Do you use telemedicine to deliver services to patients located in Indiana?

RADIO BUTTONS

a. Yes
b. No
8. What is the street address of your primary practice location (for telemedicine providers: where the patient is located)?
   TEXT-BOX (64 CHARACTER LIMIT)

9. In what city is your primary practice location?
   TEXT-BOX (64 CHARACTER LIMIT)

10. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation.
    DROP-DOWN LIST
    Please include all states’ 2-letter postal abbreviation

11. What is the 5-digit ZIP code of your primary practice location?
    TEXT-BOX (5 CHARACTER LIMIT)

12. Which of the following categories best describes the practice setting at your primary practice location?
    DROP-DOWN LIST
    a. Office/Clinic – Solo Practice
    b. Office/Clinic – Partnership
    c. Office/Clinic – Single Specialty Group
    d. Office/Clinic – Multi Specialty Group
    e. Hospital – Inpatient
    f. Hospital – Outpatient
    g. Hospital – Emergency Department
    h. Hospital – Ambulatory Care Center
    i. Federal Government Hospital
    j. Research Laboratory
    k. Medical School
    l. Nursing Home or Extended Care Facility
    m. Home Health Setting
    n. Hospice Care
    o. Federal/State/Community Health Center(s)
    p. Local Health Department
    q. Telemedicine
    r. Volunteer in a Free Clinic
    s. Other
13. Estimate the average number of hours per week spent in direct patient care at your primary practice location.

**DROP-DOWN LIST**

a. 0 hours per week  
b. 1 – 4 hours per week  
c. 5 – 8 hours per week  
d. 9 – 12 hours per week  
e. 13 – 16 hours per week  
f. 17 – 20 hours per week  
g. 21 – 24 hours per week  
h. 25 – 28 hours per week  
i. 29 – 32 hours per week  
j. 33 – 36 hours per week  
k. 37 – 40 hours per week  
l. 41 or more hours per week

14. Estimate the percentage of Indiana Medicaid patients at your primary practice location.

**RADIO BUTTONS**

a. I do not accept Indiana Medicaid  
b. Indiana Medicaid accounts for >0% - 5% of my practice  
c. Indiana Medicaid accounts for 6% - 10% of my practice  
d. Indiana Medicaid accounts for 11% - 20% of my practice  
e. Indiana Medicaid accounts for 21% - 30% of my practice  
f. Indiana Medicaid accounts for 31% - 50% of my practice  
g. Indiana Medicaid accounts for greater than 50% of my practice

15. Are you accepting new Indiana Medicaid patients at any or all of your practice locations?

**RADIO BUTTONS**

a. Yes  
b. No

16. If you selected no on the previous question, but you are enrolled as an Indiana Medicaid provider, please describe barriers to participation.

**TEXT BOX**

17. Estimate the percentage of patients on a sliding fee scale at your primary practice location.

**RADIO BUTTONS**

a. I do not offer a sliding fee scale  
b. Sliding fee patients account for >0% - 5% of my practice  
c. Sliding fee patients account for 6% - 10% of my practice  
d. Sliding fee patients account for 11% - 20% of my practice  
e. Sliding fee patients account for 21% - 30% of my practice  
f. Sliding fee patients account for 31% - 50% of my practice  
g. Sliding fee patients account for greater than 50% of my practice

18. What is the street address of your secondary practice location (for telemedicine providers: where the patient is located)? Please skip this question if you do not have a secondary practice location.

**TEXT-BOX (64 CHARACTER LIMIT)**

19. In what city is your secondary practice location? Please skip this question if you do not have a secondary practice location.

**TEXT-BOX (64 CHARACTER LIMIT)**
20. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. Please skip this question if you do not have a secondary practice location.

DROP-DOWN LIST
Please include all states’ 2-letter postal abbreviation

21. What is the 5-digit ZIP code of your secondary practice location? Please skip this question if you do not have a secondary practice location.

TEXT-BOX (5 CHARACTER LIMIT)

22. Which of the following categories best describes the practice setting at your secondary practice location? Please skip this question if you do not have a secondary practice location.

DROP-DOWN LIST
a. Office/Clinic – Solo Practice
b. Office/Clinic – Partnership
c. Office/Clinic – Single Specialty Group
d. Office/Clinic – Multi Specialty Group
e. Hospital – Inpatient
f. Hospital – Outpatient
g. Hospital – Emergency Department
h. Hospital – Ambulatory Care Center
i. Federal Government Hospital
j. Research Laboratory
k. Medical School
l. Nursing Home or Extended Care Facility
m. Home Health Setting
n. Hospice Care
o. Federal/State/Community Health Center(s)
p. Local Health Department
q. Telemedicine
r. Volunteer in a Free Clinic
s. Other

23. Estimate the average number of hours per week spent in direct patient care at your secondary practice location. Please skip this question if you do not have a secondary practice location.

DROP-DOWN LIST
a. 0 hours per week
b. 1 – 4 hours per week
c. 5 – 8 hours per week
d. 9 – 12 hours per week
e. 13 – 16 hours per week
f. 17 – 20 hours per week
g. 21 – 24 hours per week
h. 25 – 28 hours per week
i. 29 – 32 hours per week
j. 33 – 36 hours per week
k. 37 – 40 hours per week
l. 41 or more hours per week
24. Estimate the percentage of Indiana Medicaid patients at your secondary practice location. Please skip this question if you do not have a secondary practice location.

**RADIO BUTTONS**
   a. I do not accept Indiana Medicaid
   b. Indiana Medicaid accounts for >0% - 5% of my practice
   c. Indiana Medicaid accounts for 6% - 10% of my practice
   d. Indiana Medicaid accounts for 11% - 20% of my practice
   e. Indiana Medicaid accounts for 21% - 30% of my practice
   f. Indiana Medicaid accounts for 31% - 50% of my practice
   g. Indiana Medicaid accounts for greater than 50% of my practice

25. Estimate the percentage of patients on a sliding fee scale at your secondary practice location. Please skip this question if you do not have a secondary practice location.

**RADIO BUTTONS**
   a. I do not offer a sliding fee scale
   b. Sliding fee patients account for >0% - 5% of my practice
   c. Sliding fee patients account for 6% - 10% of my practice
   d. Sliding fee patients account for 11% - 20% of my practice
   e. Sliding fee patients account for 21% - 30% of my practice
   f. Sliding fee patients account for 31% - 50% of my practice
   g. Sliding fee patients account for greater than 50% of my practice

26. What is the street address of your tertiary practice location (for telemedicine providers: where the patient is located)? Please skip this question if you do not have a tertiary practice location.

**TEXT-BOX (64 CHARACTER LIMIT)**

27. In what city is your tertiary practice location? Please skip this question if you do not have a tertiary practice location.

**TEXT-BOX (64 CHARACTER LIMIT)**

28. In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. Please skip this question if you do not have a tertiary practice location.

**DROP-DOWN LIST**
   Please include all states’ 2-letter postal abbreviation

29. What is the 5-digit ZIP code of your tertiary practice location? Please skip this question if you do not have a tertiary practice location.

**TEXT-BOX (5 CHARACTER LIMIT)**
30. Which of the following categories best describes the practice setting at your tertiary practice location? Please skip this question if you do not have a tertiary practice location.

DROP-DOWN LIST
a. Office/Clinic – Solo Practice  
b. Office/Clinic – Partnership  
c. Office/Clinic – Single Specialty Group  
d. Office/Clinic – Multi Specialty Group  
e. Hospital – Inpatient  
f. Hospital – Outpatient  
g. Hospital – Emergency Department  
h. Hospital – Ambulatory Care Center  
i. Federal Government Hospital  
j. Research Laboratory  
k. Medical School  
l. Nursing Home or Extended Care Facility  
m. Home Health Setting  
n. Hospice Care  
o. Federal/State/Community Health Center(s)  
p. Local Health Department  
q. Telemedicine  
r. Volunteer in a Free Clinic  
s. Other

31. Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. Please skip this question if you do not have a tertiary practice location.

DROP-DOWN LIST
a. 0 hours per week  
b. 1 – 4 hours per week  
c. 5 – 8 hours per week  
d. 9 – 12 hours per week  
e. 13 – 16 hours per week  
f. 17 – 20 hours per week  
g. 21 – 24 hours per week  
h. 25 – 28 hours per week  
i. 29 – 32 hours per week  
j. 33 – 36 hours per week  
k. 37 – 40 hours per week  
l. 41 or more hours per week

32. Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. Please skip this question if you do not have a tertiary practice location.

RADIO BUTTONS
a. I do not accept Indiana Medicaid  
b. Indiana Medicaid accounts for >0% - 5% of my practice  
c. Indiana Medicaid accounts for 6% - 10% of my practice  
d. Indiana Medicaid accounts for 11% - 20% of my practice  
e. Indiana Medicaid accounts for 21% - 30% of my practice  
f. Indiana Medicaid accounts for 31% - 50% of my practice  
g. Indiana Medicaid accounts for greater than 50% of my practice
33. Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. Please skip this question if you do not have a tertiary practice location.

   RADIO BUTTONS

   a. I do not offer a sliding fee scale
   b. Sliding fee patients account for >0% - 5% of my practice
   c. Sliding fee patients account for 6% - 10% of my practice
   d. Sliding fee patients account for 11% - 20% of my practice
   e. Sliding fee patients account for 21% - 30% of my practice
   f. Sliding fee patients account for 31% - 50% of my practice
   g. Sliding fee patients account for greater than 50% of my practice