



# INDIANA UNIVERSITY

SCHOOL OF MEDICINE

Bowen Center for Health Workforce Research and Policy

## 2019 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?

**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
- ee. Plastic Surgery
- ff. Preventive Medicine/Public Health
- gg. Psychiatry
- hh. Pulmonology
- ii. Radiation Oncology
- jj. Radiology
- kk. Rheumatology
- ll. Surgery (General)
- mm. Thoracic Surgery
- nn. Urology
- oo. Vascular Surgery
- pp. Other Specialties

7. Do you use telemedicine to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; the delivery of health care services using electronic communications and information technology, including: secure videoconferencing, interactive audio-using store and forward technology, or remote patient monitoring technology between a provider in one (1) location and a patient in another location)?

**RADIO BUTTONS**

- a. Yes

b. No

8. Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana) Please check all that apply.

CHECKBOXES

- a. Addiction counseling
- b. Dementia/Alzheimer's care
- c. Hepatitis C Treatment/Management
- d. High-risk Pregnancy services
- e. HIV/AIDS Treatment/Management
- f. Labor and delivery services
- g. MAT (Medication Assisted Treatment) - Methadone
- h. MAT (Medication Assisted Treatment) - Buprenorphine
- i. MAT (Medication Assisted Treatment) - Naltrexone
- j. Post-natal services
- k. Pre-natal services
- l. Screening for addiction (ex: SBIRT)
- m. Screening for high-risk pregnancy
- n. Treatment of OUD-affected Pregnant Women
- o. None of the above

9. Please indicate the population groups to which you provide services:

CHECKBOXES

- a. Newborns
- b. Children (ages 2-10)
- c. Adolescents (ages 10-19)
- d. Adults
- e. Geriatrics (ages 65+)
- f. Pregnant women
- g. Inmates
- h. Disabled individuals
- i. Individuals in recovery
- j. None of the above

10. What is the street address of your primary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A"

TEXT-BOX (64 CHARACTER LIMIT)

11. In what city is your primary practice location? If this does not apply, please indicate "N/A"

TEXT-BOX (64 CHARACTER LIMIT)

3. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select "N/A"

DROP-DOWN LIST

Please include all states' 2-letter postal abbreviation along with an option for N/A

12. What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"

TEXT-BOX (5 CHARACTER LIMIT)

13. Which of the following categories best describes the practice setting at your primary practice location? If this does not apply, please select “not applicable.”

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
- t. Not applicable

14. Estimate the average number of hours per week spent in direct patient care at your primary practice location. If this does not apply, please select “not applicable.”

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
- m. Not applicable

15. Estimate the percentage of Indiana Medicaid patients at your primary practice location. If this does not apply, please select “not applicable.”

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
- h. Not applicable

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

RADIO BUTTONS

- a. Yes
- b. No

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

TEXT BOX

18. Estimate the percentage of patients on a sliding fee scale at your primary practice location. If this does not apply, please select “not applicable.”

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
- h. Not applicable

19. What is the street address of your secondary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate “N/A”.

TEXT-BOX (64 CHARACTER LIMIT)

20. In what city is your secondary practice location? If this does not apply, please indicate “N/A”.

TEXT-BOX (64 CHARACTER LIMIT)

21. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select “N/A”

DROP-DOWN LIST

Please include all states’ 2-letter postal abbreviation along with an option for N/A

22. What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate “N/A”.

TEXT-BOX (5 CHARACTER LIMIT)

23. Which of the following categories best describes the practice setting at your secondary practice location? If this does not apply, please select “not applicable.”

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
- t. Not applicable

24. Estimate the average number of hours per week spent in direct patient care at your secondary practice location. If this does not apply, please select “not applicable.”

**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
- m. Not applicable

25. Estimate the percentage of Indiana Medicaid patients at your secondary practice location. If this does not apply, please select “not applicable.”

**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
- h. Not applicable

26. Estimate the percentage of patients on a sliding fee scale at your secondary practice location. If this does not apply, please select “not applicable.”

**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
- h. I am not currently practicing

27. What is the street address of your tertiary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate “N/A”.  
TEXT-BOX (64 CHARACTER LIMIT)

28. In what city is your tertiary practice location? If this does not apply, please indicate “N/A”.  
TEXT-BOX (64 CHARACTER LIMIT)

29. In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select “N/A”  
DROP-DOWN LIST  
Please include all states’ 2-letter postal abbreviation along with an option for N/A

30. What is the 5-digit ZIP code of your tertiary practice location? If this does not apply, please indicate “N/A”.  
TEXT-BOX (5 CHARACTER LIMIT)

31. Which of the following categories best describes the practice setting at your tertiary practice location? If this does not apply, please select “not applicable.”

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
- t. Not applicable

32. Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. If this does not apply, please select “not applicable.”

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
- m. Not applicable

33. Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. If this does not apply, please select “not applicable.”

**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
- h. Not applicable

34. Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. If this does not apply, please select “not applicable.”

**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
- h. Not applicable