



INDIANA UNIVERSITY

SCHOOL OF MEDICINE

Bowen Center for Health Workforce Research and Policy

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
- 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?

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