

Study ID:

1-6

CARD 01

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## IMPROVING CHRONIC ILLNESS CARE EVALUATION



### Organization Characteristics Survey for ICICE Contact

#### **Statement of Confidentiality**

Completion of this survey is voluntary. You may choose to fill out this survey or not. You may skip any question that you do not want to answer. Please understand that your answers are completely private and confidential. Your responses will be available to researchers on the Improving Chronic Illness Care Evaluation for the purposes of aggregate analysis only.

#### **Benefit to You and Your Organization**

By completing this survey you will be contributing to your organization's efforts to improve the quality of care for your patients.

If you have any questions or want to know more about this study, please call Will Nicholas at 1-888-838-3075. **PLEASE RETURN THIS SURVEY DIRECTLY TO RAND IN THE ENCLOSED SELF-ADDRESSED ENVELOPE. THANK YOU VERY MUCH FOR YOUR TIME AND PARTICIPATION.**

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## INSTRUCTIONS

Before completing this survey, please read it through to become familiar with the questions. Complete those questions for which you have the information and ask other people in your organization (possibly from human resources, finance, or clinical settings) for answers to any remaining questions.

### GENERAL BACKGROUND AND SIZE INFORMATION

1. What is the legal organizational form of your organization?

Not-for-Profit (501C(3))	[     ]	9/
Other Not-for-Profit (includes public and district hospitals )	[     ]	
For-Profit	[     ]	10-29/
Other (please indicate)	[     ] _____	

2. At present, how large is your organization in regard to :

a) # of FTE employees: _____	30-34/
b) # of physicians and other health professionals who are affiliated with your organization, but not employed by it: _____	35-39/
c) Annual operating budget: \$ _____ (for the most recent fiscal year ending _____).	40-49/ 50-59/
d) <u>For Hospitals</u> : For the most recent fiscal year ending _____:	60-61/
1) How many staffed beds are there in your hospital? _____	62-67/
2) What is the average occupancy rate? _____	68-70/
3) Are you a member of a health system or network? Yes ____ No ____	71/
e) <u>For Health Plan</u> : For the most recent fiscal year ending _____:	72-73/
1) How many enrollees are there in your plan? _____	74-80/
	<span style="border: 1px solid black; border-radius: 50%; padding: 2px;">CARD 02</span> 7-8/
f) <u>For Physician Group</u> : For the most recent fiscal year ending _____:	9-10/
1) How many physicians are in your group practice? _____.	11-14/
2) What was the total # of patient visits for the most recent fiscal year? _____.	15-20/

**FINANCIAL INFORMATION** (Your organization's financial office may be the best source for this information).

3. Payment Sources

- a) What percentage of your patient revenue comes from each of the following sources:
- |                |             |        |
|----------------|-------------|--------|
| Medicare       | _____%      | 21-23/ |
| Medicaid       | _____%      | 24-26/ |
| Commercial     | _____%      | 27-29/ |
| Self-pay       | _____%      | 30-32/ |
| <b>Total =</b> | <b>100%</b> |        |
- b) Approximately how many different insurance plans do you have contacts with?  
\_\_\_\_\_ 33-37/
- c) How many different insurance plans account for 50% of your business? For example, for some organizations, 3 plans account for 50% of their business. For others it might take 10 or more plans. How many is it for your organization?  
\_\_\_\_\_ 38-40/
- d) Does your organization own an insurance plan that provides coverage for people other than your own employees ?
- Yes [     ] 41/
- No [     ]
- If **YES**: What percentage of the organization's patients revenue comes from this plan? \_\_\_\_\_% 42-44/

4. Revenue Sources

- a) What percentage of the operating revenues of your organization are Medicare revenue under DRGs? \_\_\_\_\_% 45-47/
- b) Capitation is defined as the pre-determined lump sum payment to care for patients regardless of how many or how few services they may need. Given this definition, what percentage of the operating revenues of your organization come from capitated payment (not including DRGs)? \_\_\_\_\_% 48-50/

5. For your most recent fiscal year, please check the box below that best reflects your organization's financial situation.

- a) Operating expenses exceeded operating revenue by > 25%  51/
- b) Operating expenses exceeded operating revenue by > 11-24%  52/
- c) Operating expenses exceeded operating revenue by > 1-10%  53/
- d) Broke even  54/
- e) Operating revenue exceeded operating expenses by > 1-10%  55/
- f) Operating revenue exceeded operating expenses by > 11-24%  56/
- g) Operating revenue exceeded operating expenses by > 25%  57/

**HUMAN RESOURCES INFORMATION** (Your organization's human resources office may be the best source for this information.)

6. Performance Appraisal and Rewards

a)	What percentage of nurses and other hospital staff are paid by:	What percentage of physicians associated with your organization are paid by:	
1) straight salary only?	_____%	_____%	58-63/
2) salary and bonus related to incentive?	_____%	_____%	64-69/
3) gain sharing program?	_____%	_____%	70-75/
4) other? (please fill in)	_____%	_____%	76-81/
	<b>TOTAL</b>	<b>100%</b>	<b>100%</b>

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b) Do any staff receive any *additional pay* for helping to achieve predetermined service quality, patient care quality, or outcome of care objectives?

Yes [      ] 9/

No [      ]

If **YES**: Approximately what percentage receive such pay? \_\_\_\_\_% 10-12/

- c) Do any staff receive any *additional pay* for saving costs?
- Yes [     ] 13/  
 No [     ]
- If **YES**: Approximately what percentage receive such pay? \_\_\_\_\_% 14-16/
- d) Do any staff receive any *non-financial rewards* for helping to achieve predetermined service quality, patient care quality or outcomes of care objectives?
- Yes [     ] 17/  
 No [     ]
- If **YES**: please briefly describe \_\_\_\_\_ 20-49/  
 \_\_\_\_\_
- e) Do any employees receive any *non-financial rewards* for saving costs?
- Yes [     ] 50/  
 No [     ]
- If **YES**: please briefly describe \_\_\_\_\_ 51-80/  
 \_\_\_\_\_
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- f) What percentage of employees' pay is based on their individual performance vs. group/team performance?
- 1) individual performance \_\_\_\_\_% 9-11/  
 2) group/team performance \_\_\_\_\_% 12-14/
- TOTAL = 100%**
- g) How frequently is employee performance formally reviewed?
- 1) once a year \_\_\_\_\_  
 2) twice a year \_\_\_\_\_ 15/  
 3) quarterly \_\_\_\_\_  
 4) monthly \_\_\_\_\_  
 5) other \_\_\_\_\_ (Please specify: \_\_\_\_\_). 16-35/



11. Can the appointment system be used to schedule pro-active follow-up visits?  
 Yes [     ] 50/  
 No [     ]
12. Are evidence-based guidelines used as the basis for clinical improvement?  
 Yes [     ] 51/  
 No [     ]
13. Does your organization use proven provider behavior change methods to implement guidelines and integrate them into provisions of care?  
 Yes [     ] 52/  
 No [     ]
14. How do primary care clinicians and specialists communicate/collaborate? (Please choose one.)  
 \_\_\_\_\_ primarily through traditional referral or 53/  
 \_\_\_\_\_ with a designated specialist team working closely with primary care clinicians to improve their care
15. Does your organization communicate to all providers that they are expected to document patients' self-management goals and plans ?  
 Yes [     ] 54/  
 No [     ]
16. Do you routinely make available the following option for self-management support?  
 a) Referrals to self-management classes or educators? Yes [     ] No [     ] 55/  
 b) Services to promote specific behavior, e.g., smoking cessation services, exercise classes? Yes [     ] No [     ] 56/

17. Have you set up links with identified community resources? If yes, please specify the links:

- a) Community weight loss programs Yes [ ] No [ ] 9/  
**If yes, specify :** \_\_\_\_\_ 10-19/
- b) Exercise programs Yes [ ] No [ ] 20/  
**If yes, specify :** \_\_\_\_\_ 21-40/
- c) Support groups Yes [ ] No [ ] 41/  
**If yes, specify :** \_\_\_\_\_ 42-61/

- d) Internet links Yes [ ] No [ ] 9/  
**If yes, specify :** \_\_\_\_\_ 10-19/
- e) ADA/Lion's club/elderly day centers  
or other resources for people with  
financial barriers to getting eye or  
foot exams Yes [ ] No [ ] 20/  
**If yes, specify :** \_\_\_\_\_ 21-40/
- f) Community podiatry services Yes [ ] No [ ] 41/  
**If yes, specify :** \_\_\_\_\_ 42-61/

- g) Health department Yes [ ] No [ ] 9/  
**If yes, specify :** \_\_\_\_\_ 10-19/

18. Does your organization have a designated staff person or resource responsible for ensuring providers and patients make maximum use of community resources?

- Yes [ ] 20/
- No [ ]

19. Do senior leaders encourage improvement efforts in chronic care?

- Yes [ ] 21/
- No [ ]

20. Do senior leaders visibly participate in improvement efforts in chronic care?  
Yes [    ] 22/  
No [    ]
21. Does the organization practice/facilitate options such as group visits, phone visits, or meeting multiple patient needs in single visits?  
Yes [    ] 23/  
No [    ]
22. Does your organization initiate follow-up by phone and visit in accordance with guidelines?  
Yes [    ] 24/  
No [    ]
23. Are patients informed about guidelines that affect their illness?  
Yes [    ] 25/  
No [    ]
24. Are patients' self-management goals and plans assessed in a standardized manner?  
Yes [    ] 26/  
No [    ]
25. Does your organization provide options for peer support, such as groups or mentoring programs?  
Yes [    ] 27/  
No [    ]
26. Are family concerns included in care planning?  
Yes [    ] 28/  
No [    ]

27. Does your organization make available a list of identified community resources in an accessible format?

Yes [     ]

No [     ]

29/

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**Along with this questionnaire, could you please provide a copy of each of the following:**

- **your organization's mission/vision statement,**
- **annual report,**
- **summary of your strategic plan, and**
- **most recent accreditation report.**

**As with everything else associated with the study, this information will be treated as confidential.**

**THANK YOU FOR COMPLETING THIS SURVEY. PLEASE RETURN THIS SURVEY TO RAND IN THE ENCLOSED SELF-ADDRESSED ENVELOPE.**