

For PROS Office Use Only:

Practice ID #: \_\_\_\_\_

Start Date: \_\_\_\_\_

Practice DB: \_\_\_\_\_ PracSurv DB: \_\_\_\_\_

## PEDIATRIC RESEARCH IN OFFICE SETTINGS (PROS) PRACTICE SURVEY

This survey is used to (1) enroll **practices** joining the PROS network and (2) periodically re-survey current network practices to obtain new and updated information. **Each practice** must complete a **Practice Survey** to become an active PROS practice. If your practice has more than one site but the sites are very similar, you need only complete one Practice Survey. If your practice has more than one site and each site is different in terms of the patient population or other important characteristics, please fill out an additional Practice Survey for each site. In addition, each practitioner within the practice wishing to join the PROS network must complete a **Practitioner Survey**. At least one Practitioner Survey has been included with this survey.

To be eligible to join PROS, practices must provide a full range of direct pediatric and/or adolescent patient primary care (including preventive services) and deliver care to an active panel of patients. Each practice that is joining PROS must select a **Contact Practitioner** who is responsible for getting this survey completed. The Contact Practitioner represents his/her practice and is responsible for communicating with the PROS Chapter Coordinator and the PROS central office at the American Academy of Pediatrics. Please follow the mailing or faxing instructions on the **last page**. Your responses will be kept strictly confidential. Results of this survey will be reported in aggregate only. Thank you.

### **PLEASE PRINT LEGIBLY**

**Name of practice/institution joining PROS:** \_\_\_\_\_

**Preferred practice mailing address:** *(If you are enrolling one practice with multiple sites, please choose one mailing address where you'd like to receive PROS correspondence.)*

\_\_\_\_\_  
department or division name (leave blank if doesn't apply)

\_\_\_\_\_  
street address / \_\_\_\_\_  
suite/room/floor/bldg or PO box #

\_\_\_\_\_  
city / state / zip code / country (if not US)

**Telephone:** \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_, extension \_\_\_\_\_

**Non-patient line/2<sup>nd</sup> Line:** \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_, extension \_\_\_\_\_

**Fax:** \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_

**PROS Contact Practitioner:** \_\_\_\_\_ / \_\_\_\_\_  
First Middle (No initials) Last Professional degrees  
(eg, MD, DO, NP, etc.)

1. Sometimes it is difficult to reach the contact practitioner. Therefore, please select and name a person in your office who will serve as the PROS Office Contact. This person, who may be a staff member or a practitioner in your office, will be responsible for coordinating office activities related to PROS. If you cannot select an office contact person at this time, please leave this blank.

Name of Office Contact: \_\_\_\_\_ / \_\_\_\_\_  
*Professional degree if clinician*

2. How many practitioners (including yourself) are associated with this practice? (Include only full- and part-time physicians, physician assistants and nurse practitioners who provide direct patient care to infants, children and/or adolescents.)

\_\_\_\_\_  
*(enter number of practitioners here)*

3. How did your practice initially hear about PROS? (Please circle only one response.)

- AAP News ..... 1
- PROS journal article ..... 2
- PROS chapter coordinator/co-chapter coordinator for my state/area ..... 3
- PROS Web Site..... 4
- Other (*specify on line below*) ..... 8

\_\_\_\_\_

4. Please indicate the practice arrangement type for the PROS practice site that you are enrolling with this form. (Please circle only one response.)

- Self-employed solo practice..... 1
- Two-physician practice ..... 2
- Pediatric group practice ..... 3
- Multi-specialty group..... 4
- Health maintenance organization (staff model) ..... 5
- Medical school or parent university..... 6
- Non-government hospital/clinic..... 7
- Non-profit community health center..... 8
- City/county/state government hospital or clinic ..... 9
- US government hospital or clinic ..... 10
- Other (please specify on the line below)..... 88

\_\_\_\_\_

5. Most PROS research studies involve a nominal honorarium to the participating practices. Reimbursement checks are normally made payable to the practice and include the practice's Tax Identification Number. Please record your practice's Tax Identification Number. (Your Tax ID number will be kept confidential and used for reimbursement purposes only.)

Practice Tax ID#: \_\_\_\_\_

6. All PROS studies need to be approved by the AAP Institutional Review Board (IRB), an Academy group designed to protect the rights of human subjects participating in scientific research and to uphold ethical standards for research. Some of our member practices can participate in studies without seeking further clearance from any local IRBs, while others (usually those affiliated with a university or other large institution) need to obtain additional local IRB approval. Please select which of the following options applies to your practice (you may need to ask your administrator):

- a) Yes, local IRB approval (in addition to AAP IRB approval) is required for my practice ..... 1
- b) No, local IRB approval is not required for my practice; AAP IRB approval is sufficient for my practice's participation in research. .... 2
- c) Unsure..... 6

7. Please estimate to the best of your ability if your practice is in one or more of the following areas. (Please circle one response for each line.)

This practice site is located in an area that has...	Yes	No	Don't Know
a) more than 50% economically disadvantaged people in the population	1	2	6
b) more than 50% minority people in the population	1	2	6
c) more than 50% uninsured people in the population	1	2	6
d) more than 50% with a language barrier in the population	1	2	6
e) a low physician-to-population ratio (<1:1,250)	1	2	6
f) many medical services not within a reasonable commuting distance	1	2	6
g) been designated a Federal Medically Underserved Area (MUA) or Population (MUP)	1	2	6

8. To the best of your ability, please estimate the percentage of your patients who are covered by the following insurance sources and systems. (Please enter a number or a "0" if none; percentages should sum to 100%.)

Private insurance, traditional fee-for-service .....	_____ %
Private insurance, managed care (HMO, IPA, PPO, POS, etc) .....	_____ %
Public insurance (Medicaid, SCHIP or other), fee-for-service .....	_____ %
Public insurance (Medicaid, SCHIP or other), managed care .....	_____ %
TRICARE (military insurance).....	_____ %
Uninsured.....	_____ %
Other ( <u>specify on line below</u> ) .....	_____ %
_____	
Don't know .....	_____ %
<b>TOTAL</b>	<b>100 %</b>

Please answer both Questions 9 and 10. Question 9 refers to Hispanic/Latino origin [eg, Cuban, Mexican, Puerto Rican, or other Hispanic] while Question 10 refers to race. Persons of Hispanic/Latino origin may be of any race therefore please respond to both questions. Hispanic/Latino is not considered a race.

**9. Please estimate the percent of Hispanic/Latino patients at this practice site.** (Please enter a number or "0" if none.)

Hispanic/Latino..... \_\_\_\_\_%

**10. Please estimate the racial composition of the patients at this practice site.** (Please enter a number or a "0" if none; percentages should sum to 100%. – Hispanic patients should be included in one of the following categories.)

White..... \_\_\_\_\_%  
 Black/African-American..... \_\_\_\_\_%  
 Asian ..... \_\_\_\_\_%  
 Native Hawaiian/Other Pacific Islander ..... \_\_\_\_\_%  
 American Indian/Alaskan Native..... \_\_\_\_\_%  
TOTAL 100 %

**11. Please describe the community in which this practice site is located.** (Circle one response.)

Urban, inner city ..... **1**  
 Urban, not inner city ..... **2**  
 Suburban ..... **3**  
 Rural ..... **4**

**12. To the best of your knowledge, do any practitioners in this practice belong to any of the following Practice-Based Research Networks (PBRNs)?** (Please check the box or boxes that apply.)

CORNET (The Ambulatory Pediatric Association-based Continuity Research Network) ..   
 NMAPedsNet (The National Medical Association Pediatric Section Research Network)...   
 Other (please specify on the line below).....

\_\_\_\_\_   
 No – none of the above (Do not check any other boxes).....

***Please double-check this survey to make sure you have completed all items. Retain a copy for your files and follow the instructions below to return your survey to PROS Central. Thank you for your assistance.***

**BY MAIL** (postage-paid envelope enclosed): PROS; Department of Practice and Research; American Academy of Pediatrics; 141 Northwest Point Boulevard; Elk Grove Village, IL 60007-1098

**BY FAX**: 847/434-8910 - Attention: Norma T. Farfán, PROS Assistant

\*Please contact Ms. Farfán at 800/433-9016, ext. 7623 or nfarfan@aap.org if you have questions.