

PPO 2008 Physician/Practitioner Survey

(continued)



PPO 2008 Physician/Practitioner Survey

Please answer all the questions by filling the appropriate box. Please mark only one box for each question.

VIII. Hospital Information

1. Do you see patients in the hospital? Yes No (If No, skip questions 2-8.)
2. Using the enclosed list of hospitals and associated codes, enter the code for your primary hospital:

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 Other: _____

Please answer questions 3 - 8 as they pertain to the primary hospital you have listed in question 2 above.

3. How would you rate the following:
- | | Excellent | Very Good | Good | Fair | Poor |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| • Overall quality of care in this hospital | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Pharmacy, in terms of providing medication correctly | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Adequacy of the number of nurses | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Competence of the nursing staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Accuracy of processing physician orders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Quality of discharge plans | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. How frequently are hospital discharges delayed because the discharge plan has not been finalized?

- Always Usually Sometimes Rarely Never

5. How strongly do you agree or disagree with the following:
- | | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| • Orders that I write for inpatients are implemented in a timely manner, so that care is not delayed. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • The timeliness of imaging and/or lab reports usually meets my needs for clinical decision-making. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • The hospital takes appropriate steps to protect the safety of my patients. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • I usually receive ER reports for my patients who are not admitted to the hospital by the time they contact me for follow-up care. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • The nursing staff have the necessary clinical skills to provide appropriate care in the specific units in which they work. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6. How long have you been admitting to this hospital? < 1 yr 1 - 5 yrs > 5 yrs

7. Do you foresee making a change in your primary hospital in the next 12 months? Yes No

8. Would you recommend this facility to your family/friends? Yes No

Thank you for completing this survey. Please return survey(s) in envelope provided, or mail directly to:
BlueCross BlueShield of Illinois
300 East Randolph, QI Dept. - 24th floor
Chicago, IL 60601

NPI # :

Blue Cross and Blue Shield of Illinois (BCBSIL) values physician input. Please complete and return this survey. BCBSIL utilizes the results for ongoing operations and the annual BCBSIL Hospital Profile.

Who was involved in completing this form? (Please check all that apply.)

- Physician/Practitioner Physician Assistant/Nurse Practitioner Nurse Office Manager Other _____

Please answer all the questions by filling the appropriate box.

Please indicate the number of physicians in your group. 1-4 5-15 16-49 50 and Above

I. PPO Overall

1. Overall, how would you rate the Blue Cross and Blue Shield of Illinois (BCBSIL) PPO program?
- | | Excellent | Very Good | Good | Fair | Poor |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

II. PPO Utilization Management (UM)

1. How would you rate the process of:
- | | Excellent | Very Good | Good | Fair | Poor | No Experience |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| • Precertifying inpatient admissions for your PPO patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Obtaining authorization of additional inpatient days for your PPO patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Case management | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
2. Have you coordinated discharge planning needs through BCBSIL Medical Management? Yes No (If No, skip to question 3.)
- 2a. If yes, how would you rate the discharge planning process?
- | | Excellent | Very Good | Good | Fair | Poor |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
3. Have you had any requests for your PPO patients (pre-certification, additional inpatient days, and/or waiver) denied in the past 3 months? Yes No (If No, go to PPO Network)
- 3a. If yes, have you appealed a denial in the past 3 months? Yes No (If No, go to PPO Network)
- 3b. If yes, how would you rate the appeal process?
- | | Excellent | Very Good | Good | Fair | Poor |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



