



## CORNET ENROLLMENT SURVEY

1. CORNET Contact Practitioner:
  - a. First Name:
  - b. Last Name:
  - c. Degree:
  - d. What is your specialty?
  
2. Note: To become a member of CORNET, you must be a current member of the Academic Pediatric Association (APA).  
Are you a current member of the APA?
  - a. Yes
  - b. No
  - c. Other (please specify)
  
3. Your position in relation to continuity program:  

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4. Contact Information:
  - a. Institution Name:
  - b. Division:
  - c. Address 1:
  - d. Address 2:
  - e. City/Town:
  - f. State/Province:
  - g. ZIP/Postal Code:
  - h. Country:
  - i. Email Address:
  - j. Phone Number/Fax:
  
5. What is your preferred method of contact? (check all that apply)
  - a. Fax
  - b. Telephone
  - c. First Class Mail
  - d. Other (please specify)

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6. Sometimes it is difficult to reach the contact practitioner. Therefore, please select a person at your site who will serve as the Office Contact. This person may be a staff member or a practitioner at your site who will be responsible for coordinating office activities related to CORNET. If you cannot select an office contact person at this time, please leave this blank.
  - a. CORNET Office Contact (Name):
  - b. Degree:
  - c. Office contact telephone number:
  - d. Office contact e-mail address:
  
7. Does your clinic use an electronic medical record (EMR) at each clinic visit?
  - a. Yes
  - b. No
  
8. Have you completed HIPAA Training for Researchers? (For involvement in future studies, we will need documentation of your completion of research training and HIPAA training)
  - a. Yes
  - b. No
  
9. At the present time, please indicate the number of pediatric residents in your training program for each of the categories below
  - a. Categorical Pediatrics
  - b. Medicine-Pediatrics
  - c. Emergency-Pediatrics
  - d. Psychiatry-Pediatrics
  - e. Other (please specify)
  - f. TOTAL
  
10. Do your residents have 2 continuity sessions per week during any year of training?
  - a. Yes
  - b. No
  
11. If yes, during which years?
  - a. PL-1 year
  - b. PL-2 year
  - c. PL-3 year
  - d. PL-4 year
  
12. How many different practice sites at your institution provide a resident continuity experience?  
\_\_\_\_\_
  
13. How many of those sites are you enrolling in CORNET?  
\_\_\_\_\_

(If you plan to enroll more than one site, contact information for these additional sites will be requested later in the questionnaire.)

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FOR SITE # 1 (Principle site)

14. Name of site:

\_\_\_\_\_

15. How many practitioners (include yourself if relevant but do not include residents) are associated with practice site #1?

- a. 1.1a Full- or Part-Time Physicians \_\_\_\_\_
- b. 1.1b Physicians Assistants \_\_\_\_\_
- c. 1.1c Nurse Practitioners \_\_\_\_\_

16. In each level of training, how many residents have their continuity experience at site #1?

- a. PL-1 \_\_\_\_\_
- b. PL-2 \_\_\_\_\_
- c. PL-3 \_\_\_\_\_
- d. PL-4 \_\_\_\_\_

17. What types of residents have their continuity experience at site #1?

- a. 1.3a. Categorical Pediatrics Yes No
- b. 1.3b. Medicine-Pediatrics Yes No
- c. 1.3c. Emergency-Pediatrics Yes No
- d. 1.3d. Psychiatry-Pediatrics Yes No
- e. 1.3e. Other Yes No

18. Please estimate total number of patients at site #1.

\_\_\_\_\_

19. Please estimate number of visits per year at site #1.

\_\_\_\_\_

20. Please estimate the percent of patients at site #1 who have a resident for a primary care provider:

\_\_\_\_\_

21. Please estimate the proportion (%) of Hispanic patients at this practice site:

\_\_\_\_\_

22. Please estimate the racial composition of the patients at practice site #1. (Please enter a number or a "0" if none; percentages should sum to 100%.)

- a. White \_\_\_\_\_
- b. Black/African-American \_\_\_\_\_
- c. Asian \_\_\_\_\_
- d. Native Hawaiian/Other Pacific Islander \_\_\_\_\_
- e. American Indian/Alaskan Native \_\_\_\_\_
- f. Other \_\_\_\_\_
- g. TOTAL \_\_\_\_\_

23. Please indicate the practice arrangement type for site #1. (Mark only one)

- a. Private practitioner's office
- b. Health maintenance organization
- c. Hospital clinic
- d. Hospital affiliated professional building
- e. Non-profit community health center
- f. Local health departments
- g. US government/military hospital or clinic
- h. Other (please specify) \_\_\_\_\_

24. Please estimate the % of patients at site #1 who are covered by the following insurance sources.

(Please enter a number or a "0" if none; percentages should sum to 100%.)

- a. Private insurance, traditional fee-for service \_\_\_\_\_
- b. Private insurance, managed care (HMO, IPA, PPO, POS, etc) \_\_\_\_\_
- c. Public insurance (Medicaid, SCHIP or other), fee-for-service \_\_\_\_\_
- d. Public insurance (Medicaid, SCHIP or other), managed care \_\_\_\_\_
- e. TRICARE (military insurance) \_\_\_\_\_
- f. Uninsured \_\_\_\_\_
- g. Other (please specify) \_\_\_\_\_
- h. TOTAL 100 % \_\_\_\_\_

25. The patient population at this site has... (please give your best estimate)

- a. % economically disadvantaged people \_\_\_\_\_
- b. % minority people \_\_\_\_\_
- c. % people with a language barrier \_\_\_\_\_

26. Please describe the community in which this practice site is located. (Mark only one)

- a. Urban, inner city
- b. Urban, not inner city
- c. Suburban
- d. Rural

27. Does this practice site see adolescents through age 18?

- a. Yes
- b. No