

ACT site number: _____

Today's Date: _____

**Activity Counseling Trial (ACT) End-of-Study Survey of
Physicians, Physician Assistants, and Nurse Practitioners**

Thank you for participating in the ACT Study. Your role in providing advice to ACT participants has been extremely important to the success of the study.

Please take a few minutes to complete this 2 page survey and return it in the enclosed, stamped envelope. Your answers should relate **ONLY** to physical activity advice you gave patients during follow-up visits at your clinic/practice. Please check **ONE** response per question unless otherwise instructed.

1. ACT physician identification number: _____
2. What type of practice do you have (check all that apply)?
 - _____ private practice
 - _____ group practice
 - _____ HMO – managed care practice
 - _____ practice affiliated with academic medical center
 - _____ other, please specify: _____
3. Do you exercise or play sports regularly (i.e., 3-5 times a week, 30 minutes at a time)? **EXERCISE**
 - _____ No _____ Yes -> If yes, check the level of exercise you are now doing:
 - EXLEVEL** _____ light exercise (slow walking or strolling, light gardening)
 - _____ moderate exercise (fast walking, moderate intensity swimming or bicycling)
 - _____ hard to very hard exercise (jogging, running, aerobics, fast swimming or bicycling)
4. Over the course of the ACT study (last 2 years), has your exercise increased, decreased, or stayed the same?
 - _____ increased _____ decreased _____ stayed the same _____ not exercising regularly **LAST2YR**
5. How often did you provide follow-up advice on physical activity when you saw patients enrolled in ACT? **FUADVICE**

(% Time	Never	Seldom	Occasionally	Often	Almost Always
	0%	25%	50%	75%	100%
	1	2	3	4	5
6. How long did it usually take to deliver follow-up physical activity advice to an ACT patient? **DELIVER**
 - _____ less than 1-2 minutes
 - _____ 3-4 min.
 - _____ 5-6 min.
 - _____ 7-9 min.
 - _____ more than 10 minutes
 - _____ don't recall
7. How much did the ACT follow-up advice increase the overall length of the office visit? **LENGTH**

Little of no increase	Some increase			Substantial increase
1	2	3	4	5
8. How useful do you think your follow-up physical activity advice was for patients trying to increase or maintain their physical activity program? **USEFUL**

Not useful at all				Very useful
1	2	3	4	5
9. Do you think your patients enrolled in ACT had fewer or more clinic visits in the last 2 years, than typical? **TYPICAL**

Don't Know	Fewer Visits	About the same	A few more visits	Many more visits
1	2	3	4	5
10. How has participating in the ACT study affected your ability to advise patients about physical activity? **ADVISE**

Stayed same/Not improved at all	Somewhat improved		Very much improved
1	2	3	4

11. Since you started providing ACT activity advice, how often do you provide advice similar to the ACT activity advice protocol to patients who are not enrolled in the ACT study? **PROVIDE**

	Never	Seldom	Occasionally	Often	Almost Always
(% Time	0%	25%	50%	75%	100%)
	1	2	3	4	5

12. Based on your experience with the ACT study, how satisfied were you with the advice/counseling the ACT health educators gave your patients (i.e., was it a reasonable plan of action for your patients). **SATISFY**

<i>Not at all satisfied</i>					<i>Very satisfied</i>
1	2	3	4	5	

13. How often do you refer your sedentary patients (not in the ACT study) to a health professional who provides physical activity counseling similar to what the ACT health educator provided? **REFER**

Never	Seldom	Occasionally	Often	Almost Always
1	2	3	4	5

14. In the future, how likely is it that you will refer sedentary patients to a health professional who would provide physical activity counseling similar to what the ACT health educator provided? **FUTREFER**

<i>Not at all likely</i>					<i>Very likely</i>
1	2	3	4	5	

15. In the future, how likely is it that you would support hiring or training a health professional at your practice (nurse, dietician, diabetes educator, exercise specialist) who would dedicate time to counseling patients about physical activity? **HIRING**

<i>Not at all likely</i>					<i>Very likely</i>
1	2	3	4	5	

16. How effective do you think ACT was at increasing/maintaining the level of physical activity in patients? **ACTLEVEL**

<i>Not effective at all</i>					<i>Very effective</i>
1	2	3	4	5	

17. What percentage of your patients in the ACT study told you their study condition or you otherwise found out their assigned condition? **PERCENT**

	None	A few	About half	Almost all	All
(% Time	0%	25%	50%	75%	100%)
	1	2	3	4	5

18. What is your overall impression of the entire ACT study? **IMPRESS**

<i>Very Poor</i>		<i>Fair</i>		<i>Very Good</i>
1	2	3	4	5

19. Has participation in ACT provided advantages to you or the clinic? Yes No **ASSET**

If Yes, please explain how it has been an advantage _____

20. Has participation in ACT been a burden or posed a disadvantage to you or the clinic? Yes No **BURDEN**

If Yes, please explain how it has been an disadvantage _____

21. In the space below or on the back, write any additional comments you have about the ACT study:

If you have any questions about the ACT study please contact: _____ at _____

Thank you for completing this survey, please return it in the attached envelope (postage paid).