SYNOPSIS OF THE 2011 HIT SURVEY FOR CHIROPRACTIC OFFICES

October 2011

The 2011 Chiropractic Office HIT Survey begins with 3 pages of introductions, instructions, and definitions that all organizations will see. After that there are two paths – one path for people who have an electronic health record (EHR) and a separate path for organizations without an EHR. The way you answer the first few questions will “skip” you through the survey to the appropriate topics.

The entire survey is copied into this document below for your information. To take the survey, use the link sent to you via e-mail. Questions? Contact Nicole Gackstetter at ngackstetter@stratishealth.org.

FOR CHIROPRACTIC OFFICES WITH EHRs

If your organization has an electronic health record (EHR), you will complete questions related to these topics:

- Meaningful Use – page 4 of the survey
- Chiropractic Office Information – page 5
- Survey Respondent Information – page 6
- EHR Implementation and Implementation Details – pages 7 and 8
- EHR Primary Questions on page 9 – or EHR System Details on page 10
- Computerized Provider Order Entry (CPOE) – page 11
- Clinical Decision Support Tools – page 12
- Lab and Test Results – page 13
- Health Information Tracking – page 14
- Patient Access to Health Information – page 15
- Patient-Specific Health Information: Education and Care Plans – page 16
- Privacy and Security – page 17
- Patient Specific Information: Consents and Preferences – page 18
- Quality Improvement – page 19
- Registries – page 20
- Information Exchange – pages 21 and 22
- Transfers and Care Transitions – page 23
- On-line Services – page 25
- General Questions – page 26

FOR CHIROPRACTIC OFFICES WITHOUT EHRs

Don’t yet have an electronic health record? You still need to take the survey, but you will be skipped through a majority of the questions. You will complete:

- Meaningful Use – page 4 of the survey
- Chiropractic Office Information – page 5
- Survey Respondent Information – page 6
- EHR Implementation – page 7
- HIT Info from Offices without an EHR – page 24
- On-line Services – page 25
- General Questions – page 26
2011 CHIROPRACTIC OFFICE HEALTH INFORMATION TECHNOLOGY (HIT) SURVEY

Survey Questions

PAGE 1: Introduction

INTRODUCTION

Welcome to the 2011 Chiropractic Office Health Information Technology (HIT) Survey.

This survey is being sent to primary contacts for chiropractic offices in Minnesota and surrounding areas identified by Stratis Health and the Minnesota Department of Health (MDH), requesting that all chiropractic offices complete this survey between the dates of October 17, 2011 and October 31, 2011.

The survey should be completed by yourself or/and another person in your chiropractic office with billing administrative responsibilities on behalf of each unique office site. To answer the survey, the appropriate respondent should:

A. Work at least part-time at the physical chiropractic office location
B. Be familiar with the office's health information technology systems
C. Have knowledge of the office's operations

Each chiropractic office site will receive a survey for completion. If you have multiple office locations and would like assistance in taking the survey or duplicating responses across more than one location, or to receive a hard copy of survey, please contact Nicole Gackstetter for assistance at ngackstetter@stratishealth.org.

The survey was prepared by adapting the 2011 MN Health Information Technology (HIT) Ambulatory Clinic Survey developed by the Minnesota Department of Health, Minnesota Community Measurement and others.

The results from the survey:
1. Will be used by organizations such as the MDH, Regional Extension Centers and other stakeholder organizations.
2. May be used by health plans for HIT related programs or incentives.
3. Will be published by MDH in a variety of formats including clinic level data for the e-Health Initiative and other e-health activities.

PAGE 2: Instructions

SURVEY INSTRUCTIONS

Step 1: Make sure you are the right person to answer the survey.
The appropriate survey respondent is someone who works at the office site and has knowledge of both office operations and health information technology. If you do not think you are the right person you should forward the survey link to someone else and exit the survey.

Step 2: Take the survey answering the questions on behalf of your office site. Use the PREVIOUS and NEXT buttons at the bottom of each page to move through the survey. When you have completed your responses, click the button that says “Click to Finish” at the end of the survey.

Need to stop and come back? Each office will get their own unique survey link. You can answer some questions, exit the survey, and return to complete the survey at a later time.

Make sure you use the link provided to you and do not share the link with other office sites.
2011 CHIROPRACTIC OFFICE HEALTH INFORMATION TECHNOLOGY (HIT) SURVEY

Requesting a hard copy of survey: To request a hard copy of the survey for review, prior to completing the on-line survey, contact Nicole Gackstetter at ngackstetter@stratishealth.org.

Survey Length and Time Expectations: Field testing found that offices without electronic health records took an average of 10-15 minutes to complete the survey. Offices with electronic health records averaged about 30-45 minutes to complete, as these series of questions reflect information required in EHR Incentives Programs and/or comparative State HIT e-health survey data.

QUESTIONS? If at any time you have questions or need more definition of terms, please contact Nicole Gackstetter at ngackstetter@stratishealth.org.

PAGE 3: Electronic Health Record System Definition

DEFINITION OF EHR

This survey will be asking questions about your electronic health record (EHR) system.

E-HEALTH DEFINITION OF AN EHR: An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized providers and staff across more than one health care organization.

NOTE: An EHR may interface with practice management system or billing system, but a practice management or billing system alone does not constitute an EHR.

A complete glossary of health information technology terms can be found on-line by clicking here: MN e-Health Resources.

If your office has multiple systems that collect patient-specific health information, answer questions concerning your primary system - the one you use for the majority of your patient records.

PAGE 4: Meaningful Use of EHR’s

The Centers for Medicare & Medicaid Services (CMS) is providing financial incentives for meaningful use of certified electronic health records starting in 2011.

All chiropractors are potentially eligible for Medicare financial incentives under the EHR Incentives Program. To be eligible for Medicare incentives, allowable Medicare Part B charges are used to calculate financial incentives which DO NOT include chiropractic managed care.

Many of the questions on this survey follow the Medicare EHR Incentives requirements. Your office may use the survey results for internal assessment of meaningful use. If you would like more information on how to access and use survey results, please contact Nicole Gackstetter at ngackstetter@stratishealth.org.

1. Are the majority of your office’s practitioners anticipating applying for Medicare financial incentives under meaningful use or the EHR incentive program?

<table>
<thead>
<tr>
<th>Planning to apply in 2011</th>
<th>Planning to apply in 2012</th>
<th>Planning to apply in 2013 or beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, under Medicare</td>
<td>No</td>
<td>Not Sure</td>
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<td></td>
</tr>
</tbody>
</table>

Q1
PAGE 5: Chiropractic Office Information

Please verify information below is correct. Make any necessary changes.

1. **Chiropractic office information:**
   - Chiropractic office site: ________________
   - Office name: ________________
   - Address: ________________
   - City: ________________
   - State: ________________
   - Zip: ________________
   - County: ________________

2. **Chiropractic office size:**
   
   **DEFINITION:**
   
   **STAFF:** Any employee who performs medical duties including chiropractic practitioners, chiropractic assistants, nurse practitioners, etc.
   
   Number of total staff (including chiropractic practitioners) ________________
   Number of chiropractic practitioners ________________

3. **Select which best describes your chiropractic office staff?**
   - Chiropractic practitioners employed by an independent chiropractic office
   - Chiropractic practitioners employed by a chiropractic office practicing in a health system or hospital

PAGE 6: Survey Respondent Information

1. **Survey responder/survey contact. Who is completing this survey?**
   
   Please verify information below is correct. Make any necessary changes.
   
   - Respondent Name: ________________
   - Respondent e-mail: ________________
   - Respondent phone number: ________________
   - Respondent title: ________________

PAGE 7: Implementation

**DEFINITION OF AN EHR:** An EHR is an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized providers and staff across more than one health care organization.

**NOTE:** An EHR may interface with practice management system or billing system, but a practice management or billing system alone does not constitute an EHR.

1. **Which statement best describes your office’s EHR system?**
   - We do not have an EHR
   - We have purchased/begun installation of an EHR but are not yet using the system
   - We have an EHR installed and in use for some of our office staff and chiropractic practitioners
   - We have an EHR installed and in all (more than 90%) areas of our chiropractic office(s)
PAGE 8: Implementation Details

DEFINITION:

STAFF: Any employee who performs medical duties including chiropractic practitioners, chiropractic assistants, nurse practitioners, etc.

1. Estimated number of total STAFF including chiropractic practitioners currently using your EHR system routinely. (SELECT FROM DROPDOWN BOX)  
2. Estimated number of CHIROPRACTIC PRACTITIONERS currently using your EHR system routinely. (SELECT FROM DROPDOWN BOX)  
3. Which phrase best describes your office's use of paper charts for patient information tracking?  
   - We do not maintain paper charts - we are entirely paperless  
   - We maintain paper charts, but the EHR is the most accurate and complete source of patient information  
   - We document all patient data in both paper charts and the EHR system  
   - We primarily use paper charts, but maintain electronic records for some clinical information  
   - Not sure  

4. Which EHR-related skills and/or roles are in greatest need in your office? This includes adding new staff or developing the current staff. (select all that apply)  
   - A person to lead the implementation of the EHR  
   - People to help design, customize, and/or maintain an EHR for use in our office  
   - People to get the EHR ready for use (entering orders, patient information, etc.)  
   - Computer/IT personnel  
   - Chiropractic practitioners, office, or other staff  
   - Trainers  
   - Other, please specify:  

PAGE 9: EHR Primary Questions

This page addresses questions about a chiropractic office's electronic health record (EHR) system.

DEFINITION OF AN EHR: An EHR is an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized providers and staff across more than one health care organization.

NOTE: An EHR may interface with practice management system or billing system but a practice management or billing system alone does not constitute an EHR.

1. What year did your office COMPLETE installation of your current EHR system?  
   - 2005 or earlier  
   - 2006  
   - 2007  
   - 2008  
   - 2009  
   - 2010  
   - 2011  
   - Installation in progress but not complete  

2. Please select your office's EHR system from the drop down list below: (SELECT FROM DROP DOWN BOX)
PAGE 10: EHR System Details

This page asks about EHR systems that are not in the drop down list from the previous page.

DEFINITION OF AN EHR: An EHR is an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized providers and staff across more than one health care organization.

NOTE: An EHR may interface with practice management system or billing system but a practice management or billing system alone does not constitute an EHR.

1. What is the name of the main EHR system your office uses? _______________

2. What is the version of your office's EHR system (if applicable)? __________

3. Does your EHR have the ability to track and record...
   - Chiropractic practitioners associated with a patient encounter? Yes ☐ No ☐ Not sure ☐
   - Clinical documentation and notes (e.g. progress notes) Yes ☐ No ☐ Not sure ☐
   - Ordered and pending labs? Yes ☐ No ☐ Not sure ☐
   - Ordered and pending diagnostic test results (e.g. labs, x-rays, MRI or other screening tests)? Yes ☐ No ☐ Not sure ☐
   - Provider orders (including referrals)? Yes ☐ No ☐ Not sure ☐
   - External documents (e.g. advanced directives or history & physicals) Yes ☐ No ☐ Not sure ☐

PAGE 11: EHR Follow-up Questions: Computerized Provider Order Entry (CPOE)

This page asks more questions about your office's use of an EHR's order entry function.

DEFINITION: Computerized Provider Order Entry (CPOE) is a computer application that allows a provider’s orders for diagnostic and treatment services (such as laboratory, imaging tests or recommended dietary changes) to be entered electronically instead of being recorded on order sheets. The computer compares the necessary checks for food and/or other allergies, or interactions with other medications, and warns the provider about potential problems.

1. Does your office have a Computerized Order Entry (CPOE) function?
   - Yes, our office currently uses CPOE for some or all provider orders
   - Yes, our office has CPOE function but this function is not in use or turned off
   - No, our office does not have CPOE

2. What percentage of provider orders (referrals, medication orders, lab and diagnostic test orders) are completed using Computerized Provider Order Entry (CPOE)?
   - 80-100% of all provider orders
   - 50-79% of all provider orders
   - 25-49% of all provider orders
   - Less than 25% of all provider orders
   - Not applicable - We do not use CPOE or the function is turned off
   - Not sure
3. What challenges does your office face in using CPOE? (select all that apply)
   - Some chiropractic practitioners use handwritten or paper orders
   - Requires staff training
   - Requires maintenance
   - Building orders into system takes time
   - Requires a system upgrade
   - Hardware issues (computers not available in all exam rooms, etc.)
   - Time too limited during patient encounter to use
   - Not applicable - there are no challenges to using CPOE
   - Other (please specify): __________________________

PAGE 12: EHR Follow-up Questions: Clinical Decision Support Tools

This page asks more questions about your office's use of decision support tools.

DEFINITION: Clinical decision support tools are health information technology functions that build on the foundation of an electronic health record to provide persons involved in patient care with general and patient-specific information that is intelligently filtered and organized to enhance patient health.

1. What electronic clinical decision making support tools do your office's practitioners and staff access DURING a patient encounter?

<table>
<thead>
<tr>
<th>Clinical guidelines based on patient problem list, gender, and age</th>
<th>Used routinely</th>
<th>Used occasionally</th>
<th>Not available</th>
<th>Function turned off / Not in use</th>
</tr>
</thead>
<tbody>
<tr>
<td>High tech diagnostic imaging decision support tools</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Allergy/dietary interaction alerts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic care plans and flow sheets</td>
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<td></td>
</tr>
<tr>
<td>Patient specific or condition specific reminders (e.g. foot exams for diabetic patients)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive care services due (e.g.: age appropriate screenings, dietary considerations)</td>
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<td></td>
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</tr>
<tr>
<td>Automated reminders for missing labs and tests (e.g. diagnostic tests)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify): __________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. What are the barriers to using tools for clinical decision making at the point of care? (select all that apply)
   - Too many false alarms/too disruptive
   - Requires staff and/or chiropractic practitioner training
   - Requires resources to build/implement
   - Requires a system upgrade
   - Software not available
   - Hardware issues (computers not available in all exam rooms, etc.)
   - Not applicable - There are no barriers to using the EHR's clinical decision making tools
   - Other (please specify): __________________________
1. Does your office use a computerized system to retrieve lab and diagnostic test results (e.g. imaging, lifestyle and/or comprehensive blood work results)?
   - Yes - chiropractic practitioners regularly use a computer to access all lab and diagnostic test results
   - Yes - chiropractic practitioners occasionally use a computer to access some, but not all, lab and diagnostic test results
   - No - chiropractic practitioners primarily use paper, faxes, or phone calls to view lab and diagnostic test results

2. Does your office incorporate lab test results (e.g. lifestyle and/or comprehensive blood work values) into the electronic health record (EHR) as structured or reportable data?
   DEFINITION: Structured and reportable data are test results that are entered into EHR systems in a digital or coded format - such as numbers or standard text values (e.g. "positive" or "negative").
   - Yes, 80-100% lab test results are recorded as structured data
   - Yes, 50-79% of lab test results are recorded as structured data
   - Yes, 25-49% of lab test results are recorded as structured data
   - Yes, less than 25% lab test results are recorded as structured data
   - No, we do not record lab test results as structured data
   - Not sure

1. Does your office maintain an up-to-date problem list for each patient's current and active diagnoses?
   DEFINITION: A problem list is a list of the patient’s diagnoses and conditions – including past conditions that may impact current health status.
   - Yes, for 80-100% of patients
   - Yes, for 50-79% of patients
   - Yes, for 25-49% of patients
   - Yes, for less than 25% of patients
   - No
   - Not sure

2. What percentage of your offices' encounters use the EHR to track and record vital signs:

<table>
<thead>
<tr>
<th></th>
<th>Less than 25%</th>
<th>25-49%</th>
<th>50-79%</th>
<th>80-100%</th>
<th>No, not collected / Function not in use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

3. Does your office use the EHR to plot and display growth charts for children ages 2-20 including Body Mass Index (BMI)?
   - Yes, for 80-100% of patients
   - Yes, for 50-79% of patients
   - Yes, for 25-49% of patients
   - Yes, for less than 25% of patients
   - No, we do not have this function or it is turned off
   - Not sure
4. Does your office track tobacco smoking using the EHR on patients 13 and older?
   - Yes, for 80-100% of patients aged 13+
   - Yes, for 50-79% of patients aged 13+
   - Yes, for 25-49% of patients aged 13+
   - Yes, for less than 25% of patients
   - No, we do not record smoking status in our EHR
   - Not sure

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**PAGE 15: EHR Follow-up Questions: Patient Access to Health Information**

1. Does your office use the EHR to provide clinical summaries for each office visit within 3 business days?

   **DEFINITION:** After-visit clinical summaries contain updated lab and test orders, procedures, and at home instructions based on clinical discussions taking place during the visit.
   - Yes, for 80-100% of all encounters
   - Yes, for 50-79% of all encounters
   - Yes, for 25-49% of all encounters
   - Yes, for less than 25% of all encounters
   - No, we can provide clinical summaries, but it typically takes longer than 3 business days
   - No, we do not use the EHR to provide clinical summaries
   - No, we do not have this function or it is turned off
   - Not sure

2. Does your office provide patients with electronic access to their health information (including lab results) within 4 business days of the information being available to the chiropractic practitioner?
   - Yes, 80-100% of patients have electronic access within 4 days
   - Yes, 50-79% of patients have access
   - Yes, 25-49% of patients have access
   - Yes, less than 25% of patients have access
   - No, we do provide electronic access to health information but it takes longer than 4 business days
   - No, we do not provide patients electronic access to health information
   - Not sure

3. Does your office provide patients with an electronic copy of their health information (including test results) on request within 3 business days? Electronic copies can be provided via patient portal, personal health records (PHR), email, USB drive, CD, or other electronic media.
   - Yes, for 80-100% of requests
   - Yes, for 50-79% of requests
   - Yes, for 25-49% of requests
   - Yes, for less than 25% of requests
   - No, we provide information on request, but it typically takes longer than 3 business days
   - No, we do not provide electronic copies of health information regularly
   - No, we do not have this capability or it is turned off
   - Not sure
4. **How does your office provide patients with electronic copies of their health information?:**

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Health Record (PHR) or Patient portal accessed with the Internet</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Secure e-mail</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Place information on a flash drive, USB drive, or CD</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Other (please specify): ______________________________</td>
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</tbody>
</table>

**PAGE 16: Patient-Specific Health Information: Education and Care Plans**

1. **Do you use your EHR to identify patient-specific education resources (e.g. at home exercise for patients with chronic low back pain and nutritional recommendations for patients with diabetes or other conditions affecting musculoskeletal system) when appropriate?**

   - ○ Yes, for 80-100% of patients
   - ○ Yes, for 50-79% of patients
   - ○ Yes, for 25-49% of patients
   - ○ Yes, for less than 25% of patients
   - ○ No, we do not use the EHR to regularly identify patient-specific educational resources
   - ○ Not sure

2. **Which phrase best describes your office’s use of CARE PLANS?**

   **DEFINITION:** Care plans are written documents for certain chronic conditions requiring advanced management. Care plans are different from after-visit summaries. They are developed with the patient and guide care management by outlining risks, goals, prevention, and actions for treatment (e.g. an action plan for patients with chronic low back pain).

   - ○ We use the EHR to provide care plans to 80-100% of patients who need them
   - ○ We use the EHR to provide care plans to 50-79% of patients who need them
   - ○ We use the EHR to provide care plans to 25-49% of patients who need them
   - ○ We use the EHR to provide care plans to less than 25% of patients who need them
   - ○ We do not use our EHR to develop and save care plans - we use a paper or manual system to create, store and distribute
   - ○ We do not/are not able to identify patients who should have care plans
   - ○ We do not develop or use written care plans
   - ○ Not sure
   - ○ Other (please specify): ______________________________

3. **How does your office provide patients with electronic copies of their care plans?:**

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Health Record (PHR) or Patient portal accessed with the Internet</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Secure e-mail</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Place information on a flash drive, USB drive, or CD</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Other (please specify): ______________________________</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
1. Does your office allow patients to set the following privacy standards:

- Define permissions for who should have access to their health record and under what circumstances
- Express preferences regarding how and under what circumstances health information may be shared with others
- Authorize the release of health information to another provider or third party

2. Does your EHR limit users to see only the information they need - based on staff function or other criteria?
   - Yes
   - No
   - Not sure

3. Does your organization conduct or review security risk analysis information and updates as necessary as part of your risk management processes?
   - Yes
   - No
   - Not sure

1. How does your office track patient consents?
   - Consents are tracked electronically (with check boxes, electronic signatures, etc.)
   - Scanned paper consents - Signed papers are scanned into the EHR
   - Paper consents only - Signed consents are filed as paper
   - Other (please specify): ____________________________

2. How does your office track advanced directives / patient preferences?
   - Electronically accessible - stored in readily accessible/consistent part of the EHR
   - Advanced directives and patient preferences are incorporated into our EHR, but are not kept in a consistent and separate place – more likely to be stored in a progress note or with other documents
   - Paper documents
   - Other (please specify): ____________________________

1. Please indicate whether your office uses data from the EHR for the following internal quality improvement efforts:

- To create benchmarks and clinical priorities
- To share data with providers
- To set goals around clinical guidelines
2. Does your office use your EHR to routinely identify and remind patients who are due for preventive care (e.g. age appropriate screenings, dietary considerations, influenza vaccinations, etc.)?
   - Yes, for 80-100% of patients
   - Yes, for 50-79% of patients
   - Yes, for 25-49% of patients
   - Yes, for less than 25% of patients
   - No, we do not use the EHR to identify and remind patients of needed preventive care
   - Not sure

3. Does your office use your EHR to routinely send patients reminders for needed follow-up care (e.g. follow-up appointments, scheduled procedures, etc.)?
   - Yes, for 80-100% of patients
   - Yes, for 50-79% of patients
   - Yes, for 25-49% of patients
   - Yes, for less than 25% of patients
   - No, we do not use our EHR to send reminders to patients for follow-up care
   - Not sure

4. Does your office use the EHR to collect and submit quality measures to an outside organization (e.g. CMS or PQRS, formerly PQRI)?

   DEFINITION: ACA (American Chiropractic Association) has identified three PQRI (PQRS) measures applicable to chiropractic practices. The measures include: pain assessment prior to initiation of treatment, function outcome assessment in chiropractic care, and health information technology adoption/use (electronic health records).
   - Yes, we collect and submit quality measures using only our EHR
   - Yes, we collect and submit quality measures using our EHR and the patient's paper chart
   - No
   - Not sure

5. What demographic information does your office capture in the EHR?

   Collected on
   |                | less than 25% | 25-49% of patients | 50-79% of patients | 80-100% of patients | Not collected / Not able to collect |
   |                | of patients   |                   |                   |                    |                                    |
   | Gender         |              |                   |                   |                    |                                    |
   | Age or Date of Birth |              |                   |                   |                    |                                    |
   | Race           |              |                   |                   |                    |                                    |
   | Ethnicity      |              |                   |                   |                    |                                    |
   | Country of origin |             |                   |                   |                    |                                    |
   | Primary language |             |                   |                   |                    |                                    |
   | Insurance type |              |                   |                   |                    |                                    |

   PAGE 20: Registries

   DEFINITION: Participation in national and/or ACA registries is currently voluntary (until projected date of 2014). If your chiropractic office is performing labs and is CLIA certified, reporting to disease registries is required.

   1. Is your office able to generate at least one report that lists patients by a specific condition?
      - Yes
      - No
      - Not sure
2. If you are able to generate reports by condition and/or disease, for which do you currently generate reports? (select all that apply)
- Asthma
- Cancer (any type)
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive heart failure
- Depression
- Diabetes
- End stage renal disease
- Stroke
- Vascular disease
- Not applicable, we cannot generate reports or this function is turned off
- Other (please specify): ____________________________

PAGE 21: Information Exchange Activities

1. Does your office routinely check insurance eligibility electronically?
- Yes, for 80-100% of patients
- Yes, for 50-79% of patients
- Yes, for 25-49% of patients
- Yes, for less than 25% of patients
- No, we do not have this function or it is turned off
- Not sure

2. Does your office routinely file claims electronically for patients?
- Yes, for 80-100% of patients
- Yes, for 50-79% of patients
- Yes, for 25-49% of patients
- Yes, for less than 25% of patients
- No, we do not have this function or it is turned off
- Not sure

3. Other than medical claims or bills, does your office electronically send and receive clinical and patient data with any of the following: (select all that apply)

DEFINITION: If you "SEND" information electronically, you are using your EHR to transmit data to another entity without an interim step. If you "RECEIVE" information electronically, your EHR automatically updates information from an external source without a manual or interim step.

<table>
<thead>
<tr>
<th></th>
<th>We routinely SEND electronic data from the EHR</th>
<th>We routinely RECEIVE electronic data from this entity</th>
<th>We do not routinely send/receive electronic data with this entity (more likely to fax, call, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Providers (outside of system, e.g., primary care)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Radiology providers/offices</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Neurology providers/offices</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Orthopedics providers/offices</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hospitals (in system/affiliated)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hospitals (outside of system)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other care settings (nursing homes, assisted living, home health agencies)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
1. Indicate the top five (5) partners with who you have the greatest need to electronically exchange health information. (select top 5):
   - Assisted Living Facilities
   - Clinics/Ambulatory Providers
   - Chiropractic Offices
   - Health Plans
   - Home Health Agencies
   - Hospice
   - Hospitals
   - Laboratories
   - Neurology Providers/Offices
   - Nursing Homes
   - Orthopedics Providers/Offices
   - Pharmacies
   - Radiology Providers/Offices
   - Tribes
   - Veteran’s Administration
   - Other, specify _______________________

2. Has your office tested (at least one time) your EHR’s ability to send key electronic information like a problem list or test results (information directly from the EHR to another entity without an interim step) to an outside provider or facility?
   - Yes
   - No
   - Not sure

3. Has your office tested (at least one time) your EHR’s ability to submit electronic data to national or disease registry?
   - Yes
   - No
   - Not sure

4. Chiropractic offices may subscribe to outside services to facilitate electronic exchange of health information across organizations. Indicate which of the following your office uses: (select all that apply)
   - We have a direct agreement with at least one other office/hospital/health system
   - We use a vendor or intermediary exchange service (e.g. Surescripts, Emdeon, ABILITY)
   - We use a non-profit Health Information Organization (e.g. CHIC)
   - Other (please specify): _______________________

5. If your organization exchanges data directly from your EHR and you are familiar with the standards of exchange, please select the exchange standards your office uses: (select all that apply)
   - Not sure
   - HL7 (Health Level Seven) for exchanging clinical data
   - HL7 CCD (Continuity of Care Document)
   - ANSI ASC X12N (standard for electronic data interchange used in insurance claims)
   - NCPDP (for exchange of pharmacy data)
   - None of the above / Not applicable
   - Other (please specify): _______________________

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6. **What are your largest challenges related to secure information exchange with outside organizations? (select all that apply)**
   - ☐ Unclear value on return on investment (ROI)
   - ☐ Subscription rates for exchange services are too high
   - ☐ Competing priorities
   - ☐ Lack of or access to technical support or expertise
   - ☐ Clinical data is not available to access from partners preventing use of health information exchange
   - ☐ Insufficient information on exchange options available
   - ☐ Inability of system to generate/receive electronic messages/transactions in standardized format
   - ☐ Capabilities of others to receive electronic data unknown or not as proficient as our organization
   - ☐ HIPAA, privacy or legal concerns
   - ☐ Other (please specify): __________________________

**PAGE 23: Transfers and Care Transitions**

1. **Does your office provide an electronic summary care record for patients who require transition (transfer of care from the office to an inpatient, outpatient, another chiropractic office or other setting)?**
   - ☐ Yes, for 80-100% of patients who transition
   - ☐ Yes, for 50-79% of patients who transition
   - ☐ Yes, for 25-49% of patients who transition
   - ☐ Yes, for less than 25% of patients who transition
   - ☐ No, we do not provide electronic summaries, we do not have this function or it is turned off
   - ☐ Not sure

2. **Does your office provide an electronic summary care record for patients who require a referral (a provider-initiated referral to another provider)?**
   - ☐ Yes, for 80-100% of patients who need a referral
   - ☐ Yes, for 50-79% of patients who need a referral
   - ☐ Yes, for 25-49% of patients who need a referral
   - ☐ Yes, for less than 25% of patients who need a referral
   - ☐ No, we do not provide electronic summaries, we do not have this function or it is turned off
   - ☐ Not sure

**PAGE 24: Chiropractic Offices without an EHR**

E-HEALTH DEFINITION OF AN EHR: An EHR is an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized office and staff across more than one health care organization.

**NOTE:** An EHR may interface with practice management system or billing system but a practice management or billing system alone does not constitute an EHR.

1. **Does your office have a plan to acquire and implement an EHR?**
   - ☐ Yes - We have purchased/are going to purchase and implement within the year
   - ☐ Yes - We are planning/exploring vendors and systems for implementation within the next 1-3 years
   - ☐ Yes - We would like to implement an EHR within the next 1-3 years, but have not yet started planning/exploring vendors
   - ☐ Yes - We are planning/exploring vendors and systems for implementation within the next 4-5 years
   - ☐ Yes - We would like to implement an EHR within the next 4-5 years, but have not yet started planning/exploring vendors
   - ☐ No - We have no plans to implement an EHR in the next 1-5 years

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2. Does your office have a Computerized Provider Order Entry (CPOE) function?

**DEFINITION:** Computerized Provider Order Entry (CPOE) is a computer application that allows a provider's orders for diagnostic and treatment services (such as laboratory, imaging tests or recommended dietary changes) to be entered electronically instead of being recorded on order sheets. The computer compares the necessary checks for food and/or other allergies, or interactions with other medications, and warns the provider about potential problems.

- [ ] Yes, our office currently uses CPOE for some or all provider orders
- [ ] Yes, our office has CPOE function but this function is not in use or turned off
- [ ] No, our office does not have CPOE

3. What are the largest challenges to EHR implementation? (select all that apply)

- [ ] Cost to acquire
- [ ] Vendor availability
- [ ] Return-on-investment concerns
- [ ] Chiropractic practitioner support
- [ ] Non-physician provider support
- [ ] Staff support
- [ ] Administration support
- [ ] Staff education and training
- [ ] Security/privacy concerns
- [ ] Internal knowledge/technical resources
- [ ] Other (please specify): ___________________________

4. Which EHR-related skills and/or roles that are in greatest need within your organization? This includes adding new staff or developing the current staff. (select all that apply)

- [ ] A person to lead the implementation of the EHR
- [ ] People to help design, customize, and/or maintain an EHR for use in our office
- [ ] People to get the EHR ready for use (entering orders, patient information, etc.)
- [ ] Computer/IT personnel
- [ ] Providers, office, or other staff
- [ ] Trainers
- [ ] Other, please specify: ___________________________
1. Does your office or organization offer any of the following on-line services:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Yes, our office or organization offers this service</th>
<th>No, our office or organization does not have this service</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-line appointment scheduling (patients use the Internet to contact the office for an appointment)</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>On-line bill payment</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>E-visits (scheduled time for provider-patient interaction via electronic medium such as e-mail or Internet)</td>
<td>○</td>
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<tr>
<td>Secure e-mail for communication between providers and patients</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Electronic visit reminders</td>
<td>○</td>
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<tr>
<td>Blogs or on-line support groups</td>
<td>○</td>
<td>○</td>
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</tbody>
</table>

2. Does your office offer an on-line personal health record (PHR) for patients to view and track health activities?

- ○ Yes
- ○ No
- ○ Not sure

PAGE 26: General Questions

1. Briefly describe your experience with electronic health records and health information exchange: __

2. Which organizations’ resources have you used to assist your chiropractic office in adopting and using of EHRs and achieving health information exchange? Select all that apply. If none, indicate which resources you are most likely to use.

<table>
<thead>
<tr>
<th>Resource Description</th>
<th>Yes; and we are likely to continue using this resource in the future</th>
<th>Yes; but we’re not sure if we will use this resource in the future</th>
<th>No; but we would be willing to use this resource for assistance</th>
<th>No; we will not use this resource for assistance</th>
<th>Not sure</th>
<th>Never heard of</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government</strong></td>
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<tr>
<td>Federal Gov’t – Office of National Coordinator</td>
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<tr>
<td>Federal Gov’t - CMS</td>
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<tr>
<td>State Gov’t – Human Services Dept</td>
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<tr>
<td>State Gov’t – Health Dept</td>
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<tr>
<td>REC – Regional Extension Center</td>
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<td><strong>Association</strong></td>
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<tr>
<td>Minnesota Chiropractic Assn</td>
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<tr>
<td>Chiropractic Assoc of SD (CASD)</td>
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<tr>
<td>Chiropractic Associated of MN (CAMN)</td>
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</table>
### 2011 CHIROPRACTIC OFFICE HEALTH INFORMATION TECHNOLOGY (HIT) SURVEY

<table>
<thead>
<tr>
<th></th>
<th>Yes; and we are likely to continue using this resource in the future</th>
<th>Yes; but we’re not sure if we will use this resource in the future</th>
<th>No; but we would be willing to use this resource for assistance</th>
<th>No; we will not use this resource for assistance</th>
<th>Not sure</th>
<th>Never heard of</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>American Chiropractic Assn (ACA)</strong></td>
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<tr>
<td><strong>College or University</strong></td>
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<tr>
<td>College of St. Scholastica</td>
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<tr>
<td>Normandale Community College</td>
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<tr>
<td>Northwestern Health Services</td>
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<tr>
<td>Palmer</td>
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<tr>
<td>University of MN</td>
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<tr>
<td>Other College or University, specify _________</td>
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<tr>
<td><strong>Other Organizations</strong></td>
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<tr>
<td>ChiroCare of MN</td>
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<tr>
<td>ChiroCare of WI</td>
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<tr>
<td>HSM (Health Service Management)</td>
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<tr>
<td>Ingenix</td>
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<td>Optum Health</td>
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<tr>
<td>Stratis Health</td>
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<tr>
<td>United Health Care</td>
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<tr>
<td>Other resource, specify _____________________</td>
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<tr>
<td>Other resource:</td>
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</tbody>
</table>

3. **General Comments:** ____________________________________________

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**PAGE 27: Thank You!**

You have completed the 2011 Chiropractic Office HIT Survey!

**Survey Follow Up**

Stratis Health will follow up with chiropractic offices as needed to clarifying survey responses beginning November 7, 2011.

If you have further questions about the HIT Chiropractic Office Survey, please contact Nicole Gackstetter at ngackstetter@stratishealth.org.