The 2014 HIT Survey begins with three pages of introductions, instructions, definitions, followed by and background information and electronic health record (EHR) implementation questions that all respondents see. From this point, clinics that have an EHR follow a series of questions about utilization, while clinics without EHRs follow a separate series regarding plans to implement and barriers to implementation. All clinics are then asked a series of questions about related health information technologies that can be separate from an EHR, as well as meaningful use attestation information.

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Minnesota Department of Health, Office of Health Information Technology
http://www.health.state.mn.us
EHR Implementation

3. Which statement best describes your clinic’s electronic health record (EHR) system?
   
   DEFINITION: An EHR is a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting. 
   
   - We do not have an EHR (skip to Q47, non-adopters)
   - 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 clinic staff and providers
   - We have an EHR installed and in all (more than 90%) areas of our clinic

4. Was your clinic’s first EHR system live on or before January 1, 2014?
   
   DEFINITION: An EHR is a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting. 
   
   - Yes (skip to Q8)
   - No
   - Not sure

5-7. On what date did your clinic go live with its first EHR system?

   MONTH dropdown (required)
   DAY dropdown (optional)
   YEAR dropdown (required)

8. Does your clinic currently use a 2014 ONC certified EHR system with the necessary components to attest?

   DEFINITION: A certified EHR meets the adopted standards and certification criteria to help providers and hospitals achieve the stage Meaningful Use (MU) objectives and measures established by the Centers for Medicare and Medicaid Services (CMS) for their stage of meaningful use and type of practice. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting. 
   
   - Yes
   - No
   - Not sure

9. Please select your clinic’s current EHR system vendor from the drop-down list below:

   (SELECT FROM DROP DOWN BOX)
   If not listed, what is your system? (Open response)
10. Which phrase best describes your clinic’s use of paper charts for patient information tracking?
   - We do not maintain paper charts - we are entirely paperless
   - We primarily use electronic records, but maintain paper charts for some clinical 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

**Computerized Order Entry**

11. Does your clinic have a Computerized 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 medications, laboratory, and other tests) to be entered electronically instead of being recorded on order sheets or prescription pads. The computer can then compare the order against standards for dosing, checks for allergies or interactions with other medications, and warns the provider about potential problems. [http://www.health.state.mn.us/e-health/glossary/c.html](http://www.health.state.mn.us/e-health/glossary/c.html)

   - Yes, our clinic currently uses CPOE for some or all provider orders
   - Yes, our clinic has CPOE function but this function is not in use or turned off (skip to Q10)
   - No, our clinic does not have CPOE (skip to Q13)

12. What percentage of provider orders (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 sure

13. What challenges does your clinic face in using CPOE? (select all that apply)

   - Building orders into system takes time
   - Hardware issues (e.g., computers not available in all exam rooms)
   - Requires a redesign of workflow processes
   - Requires a system upgrade
   - Requires maintenance
   - Requires staff training
   - Some providers prefer to use handwritten or paper orders
   - Time too limited during patient encounter to use
   - Limited system functionality
   - Not sure
   - Not applicable - there are no challenges to using CPOE
   - Other (please specify): __________________________
Clinical Decision Support

14. Please indicate how often the following electronic clinical decision support tools are used by your clinic's providers and staff DURING a patient encounter? (Respond for each tool listed)

DEFINITION: Clinical Decision Support (CDS) refers broadly to providing clinicians or patients with clinical knowledge and patient-related information, intelligently filtered or presented at appropriate times, to enhance patient care. [http://www.himss.org/ASP/topics_clinicalDecision.asp](http://www.himss.org/ASP/topics_clinicalDecision.asp)

Scale:
- Used routinely
- Used occasionally
- Function not available
- Function turned off/Not in use

Items:
- a. Automated reminders for missing labs and tests (e.g., overdue HbA1c labs)
- b. Chronic disease care plans and flow sheets
- c. Clinical guidelines based on patient problem list, gender, and age
- d. High tech diagnostic imaging (HTDI) decision support tools
- e. Medication guides/alerts
- f. Patient-specific or condition-specific reminders (e.g., foot exams for diabetic patients)
- g. Preventive care services reminders (e.g., mammograms for women who are not current with screening)

15. What are the barriers to using tools for clinical decision making at the point of care? (select all that apply)

- Functionality not available for our specialty
- Hardware issues (e.g., computers not available in all exam rooms)
- Lack of resources to build/implement
- Lack of staff and/or provider training
- Requires a redesign of workflow processes
- Requires a system upgrade
- Software not available
- Too many false alarms/too disruptive
- Not sure
- Not applicable - There are no barriers to using the EHR's clinical decision making tools
- Other (please specify): ________________________
Other EHR Functions

16. Does your clinic use a computerized system to retrieve lab and diagnostic test results (e.g., HbA1c values and mammogram results)?
   ○ Yes, providers regularly use a computer to access all lab and diagnostic test results
   ○ Yes, providers occasionally use a computer to access some, but not all, lab and diagnostic test results
   ○ No, providers primarily use paper, faxes, or phone calls to view lab and diagnostic test results

17. Does your clinic maintain an up-to-date problem list for each patient’s current and active diagnoses?
   ○ 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

18. Does your clinic’s EHR automatically identify patient-appropriate education resources when appropriate (e.g., tobacco cessation resources for smokers)?
   ○ Yes
   ○ No
   ○ Not sure

19. Does your clinic document the existence of a patient’s advance directive in your EHR?
   Definition: An advance directive is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions. From http://www.patientsrightscouncil.org/site/advance-directives-definitions/
   ○ Yes
   ○ No (skip to Q22)
   ○ Not sure (skip to Q22)

20. What percent of your clinic’s patients 65 years of age and older have an advance directive in your EHR?
   ○ 80-100% of patients age 65 and older
   ○ 50-79% of patients age 65 and older
   ○ 25-49% of patients age 65 and older
   ○ Less than 25% of patients age 65 and older
   ○ Not sure

21. How do you store advance directive information?
   ○ Incorporated into our EHR, but not kept in a consistent and separate place - more likely to be stored in a progress note or with other documents
   ○ Electronically accessible - stored in readily accessible/consistent part of the EHR
   ○ Paper documents
   ○ Not sure
22. What percentage of your clinic's face-to-face provider encounters used the EHR to track and record vital signs in the past year? (answer for each item)

Scale - Percentage of encounters
80-100%
50-79%
25-49%
Less than 25%
No, not collected / Function not in use / Not sure

Items:
  a. Height
  b. Weight
  c. Blood pressure
  d. Body Mass Index

23. For what percentage of patients does your clinic capture demographic information in the EHR?

Scale - Percentage of patients
80-100%
50-79%
25-49%
Less than 25%
No, not collected / Function not in use / Not sure

Items:
  a. Race
  b. Hispanic Ethnicity
  c. Country of origin
  d. Preferred language
  e. Insurance type

24. Does your EHR system have the ability to capture and report more than one race per patient?
   ○ Yes
   ○ No
   ○ Not sure

25. Does your EHR system have the ability to capture and report granular (detailed) ethnicity information?
   Definition: Granular Ethnicity is defined as a person's ethnic origin or descent, “roots” or heritage, or the place of birth of the person’s parents or ancestors. An example of granular ethnicity would include “Hmong”, “Vietnamese”, or “Chinese” that would map/aggregate to the category of “Asian”.
   ○ Yes
   ○ No (skip to Q27)
   ○ Not sure (skip to Q27)
26. For approximately what percent of patients are you capturing detailed ethnicity information?
   - 80-100% of patients
   - 50-79% of patients
   - 25-49% of patients
   - less than 25% of patients
   - Not sure

27. Is your clinic able to generate at least one report that lists patients by a specific condition (i.e., a disease registry)?
   - Yes
   - No (skip to Q29)
   - Not sure (skip to Q29)

28. For which diseases do you currently generate reports from your EHR? (select all that apply)
   - Asthma
   - Cancer (any type)
   - Chronic Obstructive Pulmonary Disease (COPD)
   - Congestive heart failure
   - Dementia/Alzheimers
   - Depression
   - Diabetes
   - End stage renal disease
   - Hypertension
   - Obesity
   - Stroke
   - Vascular disease
   - Not sure
   - Other (please specify): _________________________________

Privacy/Patient Consent

29. Indicate if your clinic's EHR allows patients to set each of the following privacy standards:
   Scale:
   - Yes
   - No
   - Not sure

   Items:
   a. Define permissions for who should have access to their health record and under what circumstances
   b. Express preferences regarding how and under what circumstances health information may be shared with others
   c. Authorize the release of health information to another provider or third party
30. Does your EHR limit users to see only the information they need based on their role or staff function?
   - Yes
   - No
   - Not sure

31. 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

32. How does your clinic 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): _______________________

**Reporting, Quality Improvement & Patient Safety**

33. Please indicate the extent to which you agree that your EHR system has helped providers in your clinic...
   
   Scale:
   - Agree
   - Agree somewhat
   - Disagree
   - Not sure or not applicable

   Items:
   a. Be alerted to critical lab values
   b. Be alerted to potential medication errors
   c. Be reminded to provide preventive care (e.g., vaccine)
   d. Enhance patient care in your clinic?
   e. Identify needed lab test (e.g., HbA1c or LDL)
   f. Order fewer tests due to better availability of lab results
   g. Order more on-formulary drugs (e.g., as opposed to off-formulary drugs)
   h. Provide care that meets clinics guidelines for patients with chronic disease
34. Please indicate whether your clinic uses data from the EHR for the following internal quality improvement efforts:
   Scale:
   Yes
   No
   Not sure

   Items:
   a. To create benchmarks or develop clinical priorities
   b. To share data with providers
   c. To set goals around clinical guidelines
   d. To support professional development activities (e.g., certifications)

35. Does your clinic use your EHR to routinely identify and remind patients who are due for preventive care (e.g., colorectal cancer screenings, influenza vaccinations, etc.)?
   ○ Yes, for 80-100% of patients
   ○ Yes, for 50-79% of patients
   ○ Yes, for less than 50% of patients
   ○ Yes, for 25-49% of patients
   ○ No, we do not use the EHR to identify and remind patients of needed preventive care
   ○ Not sure
   ○ Not applicable – we do not provide primary care services

36. Does your clinic 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 less than 50% of patients
   ○ Yes, for 25-49% of patients
   ○ No, we do not use our EHR to send reminders to patients for follow-up care
   ○ Not sure

37. Does your clinic use the EHR to collect and submit quality measures to an outside organization (e.g., Centers for Medicare & Medicaid Services, Physician Quality Reporting Initiative, or Minnesota Community Measurement)?
   ○ 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, we do not submit quality measures
   ○ Not sure
Health Information Exchange

38. Is your EHR able to generate an electronic summary of care record (e.g., a continuity of care document) for patients who require a referral to another provider, or transition from one setting of care to another (e.g., hospital, primary care clinic, nursing home, home health)?
Definitions:
- A summary of care record must include the following elements: Patient name; referring or transitioning provider's name and office contact information; procedures; encounter diagnosis; immunizations; laboratory test results; vital signs (height, weight, blood pressure, BMI); smoking status; functional status, including activities of daily living, cognitive and disability status; demographic information (preferred language, sex, race, ethnicity, date of birth); care plan field, including goals and instructions; care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider; reason for referral; current problem list; current medication list; and current medication allergy list. ([http://www.cms.gov/Regulations-and-Legislation/EHRIncentivePrograms/downloads/Stage2_EPCore_15_SummaryCare.pdf](http://www.cms.gov/Regulations-and-Legislation/EHRIncentivePrograms/downloads/Stage2_EPCore_15_SummaryCare.pdf))
  - Yes
  - Yes, we have this functionality but it is turned off or we don’t use it
  - No, we do not have this functionality
  - Not sure
  (IF TURNED OFF, NO OR NOT SURE, SKIP TO Q40)

39. For what percent of patients who require a referral or transition to another care setting does your clinic provide an electronic summary of care record to that facility (not including electronic fax or non-secure email)?
  - 80-100% of patients who require referral or transition
  - 50-79% of patients who referral or transition
  - 25-49% of patients who referral or transition
  - Less than 25% of patients who referral or transition
  - Not sure

40. With which types of health organizations does your clinic need to share patient health information, either paper/fax or electronically? (select all that apply)
- Ambulatory clinics outside of your health system
- Hospitals outside of your health system
- Local public health departments
- Minnesota Department of Health
- Home health agencies
- Behavioral health providers (e.g., mental health/substance use)
- Nursing homes
- Long-term/Post-acute care facilities other than nursing homes (e.g., rehab or assisted living)
- Social service agencies/organizations
41. For each type of organization you selected in the previous question, indicate if your clinic electronically transmits patient health information? “Electronic” exchange does not include phone, fax, non-secure email, or view/download access from another organization’s EHR.

Scale:
Yes, we electronically transmit patient health information
No, we cannot or do not electronically transmit patient health information
Don’t know

Items:
  a. Clinical/ambulatory providers outside of your health system
  b. Hospitals outside of your health system
  c. Local public health departments
  d. Minnesota Department of Health
  e. Home health agencies
  f. Behavioral health providers (for mental health and substance use treatment)
  g. Nursing homes
  h. Long-term care and post-acute care facilities other than nursing homes (e.g., rehabilitation or assisted living facilities)
  i. Social service agencies/organizations

43. For each type of clinical information received electronically from providers or sources outside your health system/organization, how do you usually integrate the information into your EHR? Select one method for each type of information.

Scale:
Usually as a fax, PDF file, static document, or scanned in
Usually as discrete standardized data (e.g., LOINC or SNOMED)
Usually as discrete data but not standardized (e.g., text or local code)
Not sure
Not applicable

Items:
  a. Summary of care record
  b. lab results
  c. medication history
  d. immunizations

44. Which of the following best describes the mechanism(s) your clinic currently uses for electronic exchange clinical health information? Select all that apply.

- Exchange capability built into your EHR (e.g., Epic Everywhere)
- Exchange using a State-Certified HIE Service Provider (see http://www.health.state.mn.us/divs/hpsc/ohit/certified.html for a listing).
- Interstate HIE and HealtheWay/eHealth Exchange/Sequoia Project (e.g., for interstate or nationwide connectivity)
- Direct secure messaging
- Connect query-based exchange
- Peer-to-peer exchange (e.g., not using a hub-type of exchange)
45. Do your providers receive automatic electronic notification (i.e., an alert) when any of their patients visit a hospital emergency department? Select all that apply.
   - Yes, from hospitals within our health system
   - Yes, from hospitals outside of our health system
   - No
   - Not sure

45. What are your largest challenges related to secure electronic health information exchange with outside organizations? (select all that apply)
   - We lack the ability to electronically exchange health information
   - Our partners are not able to electronically exchange health information
   - We do not know if our partners are able to electronically exchange health information
   - Managing consent to share information (e.g., HIPAA, privacy, or legal concerns)
   - Planning for and executing data use agreements
   - Inadequate vendor options for health information exchange
   - Inadequate technical support to implement health information exchange
   - Our IT staff do not understand our needs for health IT and/or health informatics.
   - Inadequate set-up and/or subscription fees for health information exchange
   - Leadership support
   - Unclear value on return on investment
   - Not applicable-there are no challenges related to secure information exchange with outside organizations
   - Other (please specify): __________

Non-Adopters

46. Does your clinic have a plan to acquire and implement an EHR?

DEFINITION OF AN EHR:
An EHR is a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision-making. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting.
(http://www.health.state.mn.us/e-health/glossary/e.html)

- 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 1-5 years
- Yes - We would like to implement an EHR within the next 1-5 years, but have not yet started planning/exploring vendors
- No - We have no plans to implement an EHR in the next 5 years
47. Please identify if the following barriers impact your clinic's EHR implementation status:
   Scale:
   significant barrier
   somewhat of a barrier
   not a barrier

   Items:
   a. Ability to secure financing for an EHR system
   b. Access to high speed Internet (e.g., broadband, cable)
   c. Adequacy of training for you and your staff
   d. Annual cost of maintaining an EHR system
   e. Effort needed to select an EHR system
   f. Finding an EHR system that meets your practice’s needs
   g. Loss of productivity during the transition to an EHR system
   h. Reaching consensus within the practice to select an EHR
   i. Reliability of the system (e.g., EHR down or unavailable when needed)
   j. Resistance of your practice to change work habits
   k. Other (specify:______________)

ALL RESPONDENTS COMPLETE REST OF SURVEY

48. Which of the following e-health resources or workforce skills would help your clinic to advance use of HIT and/or electronic exchange of health information (HIE)? (select all that apply)
   □ Implementing an EHR system, managing EHR system updates, and/or transitioning to a new EHR system
   □ Translating clinical needs to IT staff to optimize and/or customize EHR
   □ Training staff and clinics to use the EHR system
   □ Managing workflow changes
   □ Developing policies and procedures for managing data quality
   □ Using data analytics and/or informatics
   □ Managing patient consent to share health information
   □ Mitigating security risks to help prevent data breaches
   □ Developing infrastructure to support HIE
   □ Selecting an HIE vendor and/or negotiating an agreement
   □ Establishing HIE agreements with exchange partners (e.g., Business Associate Agreement)
   □ Integrating patient data from external sources into our EHR
   □ Technical assistance to support HIE with MDH
   □ Other (please specify)
Patient Electronic Access

49. Indicate which functions your clinic offers to patients to access and use their patient health information (select all that apply):
   - View online (patient or authorized representative can access their health information online)
   - Download (patient or authorized representative can download their health information to a physical electronic media (USB, CD) or into a PDF document)
   - Transmission (patient or authorized representative can transmit their health information through any means of electronic transmission according to transport standards; this does not include downloading information to physical electronic media)
   - None of the above
   - Not sure

50. Does your clinic offer an online patient portal?
DEFINITION: A patient portal is an internet application that allows patients to access their electronic health records and permits two-way communication between patients and their healthcare providers. (Source HealthIT.gov: www.healthit.gov/patients-families/faqs/what-patient-portal)
   - Yes, we have a patient portal
   - No, we don’t have a patient portal (skip to Q52)
   - Not sure (skip to 52)

51. Indicate the features or functionalities available to the patients through the patient portal? (select all that apply)
   - Access to medication lists
   - Access to test results
   - Access to immunization records
   - Access to clinical visit summary
   - Access to care plans
   - Access to allergies list
   - Access to diagnosis/problem list
   - Access to providers’ progress notes/documentation
   - Other (please specify): ___________

52. Indicate other features or functionalities your clinic offers through the patient portal and other methods (select all that apply):
DEFINITION: Secure messaging is an approach to protect sensitive data using industry standards. It includes security features that go beyond typical email to (1) protect the confidentiality and integrity of sensitive data transmitted between systems or organizations and (2) provides proof of the origin of the data. Secure messages are encrypted bi-directionally and are stored on network or internet servers that are protected by login. Secure messaging functionality may be integrated with the EHR or maintained in a system separate and distinct from the EHR. 
   http://www.health.state.mn.us/e-health/glossary/s.html
   - Blogs or online support groups
   - Electronic reminders for visits or follow-up care
   - Electronic reminders for preventive/recommended care
☐ E-Visits
☐ Online appointment request or scheduling
☐ Online bill pay
☐ Patient education materials
☐ Secure messaging/e-mail
☐ Other (please specify): ___________

Telemedicine

53. Indicate which of the following telemedicine activities are conducted at your clinic. Select all that apply.
DEFINITION: Telemedicine/Telehealth is the use of telecommunications technologies (e.g., phones, e-mail, videos) to provide health care services to a patient who is physically not with the provider. Telemedicine can include diagnosis, treatment, education and other health care activities. (definitions attributed to the American Telemedicine Association, http://www.americantelemed.org)

Scale:
☐ Yes
☐ No
☐ Not sure

Items:

a. Originating or patient site: the patient us physically at your clinic at the time the service occurs via a telecommunications system
b. Primary care and specialist referral services: involves a primary care health professional providing a consultation with a patient or a specialist assisting the primary care physician in rendering a diagnosis.

c. Real-time teleconsultations: provider-to-provider or provider-to-patient consultation at distance using real-time videoconferencing.

d. Store-and-forward teleconsultations: provider-to-provider or provider-to-patient consultation at distance by storing digital content and then transmitting the files at another time (i.e., not real-time).

e. Remote patient monitoring: patients use mobile medical devices to perform a routine test and send the test data to a healthcare professional in real time (e.g., blood glucose, blood pressure, oxygen saturation, heart ECG, etc.).

54. For which of the following activities does your clinic use telemedicine/telehealth? (select all that apply)
☐ Chronic disease management
☐ Consumer medical and health information
☐ Correctional health – Triage
☐ Home care/Hospice
☐ ICU care using remote patient monitoring
☐ Nursing home care
☐ Pharmacy, satellite/after hours
☐ Provider and staff medical education
☐ Radiology
☐ Rehabilitation therapies
Remote patient monitoring
School health (K-12)
None
Other (please specify)_____________________________________

55. What barriers to using telemedicine/telehealth services does your clinic face? (select all that apply)
- Cost of equipment
- Cost to provide (hosting costs including staff costs)
- Insufficient bandwidth (infrastructure and/or connectivity issues)
- Lack of staff expertise/training
- Lack of staff support
- No identified need or demand for telemedicine/telehealth services
- Physicians/other clinicians not available to provide services
- Reimbursement from payers does not cover cost
- Not applicable/ we have no barriers
- Other (please specify) _________________________________

E-Prescribing

56. Which statement best describes how your patients most often receive a prescription for prescriptions that DO NOT include controlled substances?
- Most prescriptions are e-prescribed, sent electronically from our system directly to a pharmacy without an interim step from the clinic staff or patient
- Most prescriptions are created electronically and auto-faxed or manually faxed to a pharmacy
- Most prescriptions are created electronically, printed, and handed to the patient to have filled
- Most prescriptions are written by hand and either faxed to a pharmacy or handed to the patient
- None of the above / Not applicable
- Other (please specify): ________________

57. Which statement best describes how your patients most often receive a prescription for prescriptions that include controlled substances
- Most prescriptions are e-prescribed, sent electronically from our system directly to a pharmacy without an interim step from the clinic staff or patient
- Most prescriptions are created electronically and auto-faxed or manually faxed to a pharmacy
- Most prescriptions are created electronically, printed, and handed to the patient to have filled
- Most prescriptions are written by hand and either faxed to a pharmacy or handed to the patient
- None of the above / Not applicable
- Other (please specify): ________________
58. Estimate the percent of prescriptions that are e-prescribed by your clinic? (select one for each row)
DEFINITION: Prescriptions are for controlled or non-controlled substances.
DEFINITION: e-Prescribing is sending prescriptions electronically from a provider's system to a pharmacy without an interim step from the hospital staff or patient.

Scale:
- 80-100% of prescriptions
- 50-79% of prescriptions
- 25-49% of prescriptions
- Less than 25% of prescriptions
- Not sure

Items:
- For prescriptions that DO NOT include controlled substances
- For prescriptions that include controlled substances

59. Are providers electronically alerted to any of the following AT THE POINT OF PRESCRIBING: (select all that apply)
- Cost comparison of medications
- Generic alternatives
- Patient-specific formulary information
- Potential drug-drug interactions
- Potential drug-allergy interactions
- Not applicable - our electronic systems do not alert providers to any of the above
- Not sure

61. What challenges does your clinic face in e-prescribing? (select all that apply)
- Capabilities of pharmacy to receive and send electronic data unknown
- Capability of our EHR or prescribing software to e-prescribe
- Do not have authentication capability to e-prescribe controlled substances
- HIPAA, privacy or legal concerns
- Lack of access to technical support or expertise
- Pharmacy does not receive e-prescriptions
- Provider preference to write prescriptions by hand
- Not applicable – there are no challenges to e-prescribing
- Other (please specify): ____________________
Administrative Transactions

Minnesota statutes, section 62J.536 requires that providers, payers, and intermediaries such as clearinghouses exchange certain health care business (administrative) transactions electronically, using a single, uniform data format and content based on national standards (ASC X12). Please indicate the extent to which your clinic uses these standards for the following administrative transactions.

62. Does your clinic routinely check insurance eligibility electronically using the standard known as the “270/271”?
   - Yes, for 80-100% of patients
   - Yes, for 50-79% of patients
   - Yes, for less than 50% of patients
   - No
   - Not sure

63. Does your clinic receive electronic remittance advices (ERA) using the standard known as the “835”?
   - Yes, for 80-100% of claims
   - Yes, for 50-79% of claims
   - Yes, for less than 50% of claims
   - No
   - Not sure

64. Does your clinic receive electronic acknowledgements of their claims submissions using any of the standards known as the “TA1,” “999,” or “277CA”?
   - Yes, for 80-100% of claims
   - Yes, for 50-79% of claims
   - Yes, for less than 50% of claims
   - No
   - Not sure