Welcome to the 2015 Health Information Technology (HIT) Ambulatory Clinic Survey.

The Minnesota Department of Health (MDH) established the Minnesota Statewide Quality Reporting and Measurement System (SQRMS) in December 2009 through the adoption of Minnesota Rules, Chapter 4654. This measurement system requires physician clinics, hospitals, and ambulatory surgical centers to submit data on a defined set of quality measures that will be publicly reported. As part of these requirements, all physician clinics must complete this survey on health information technology between the dates of February 17, 2015 and March 17, 2015.

Survey results inform the status and use of electronic health records, health information exchange, and other health information technology use by physician clinics across Minnesota. The results are used by MDH, MN e-Health Initiative, MN Community Measurement and others to:

- Measure Minnesota’s status on achieving state and national goals to accelerate adoption and use of electronic health records and other HIT, and to achieve interoperability of health information;
- Identify gaps and barriers to enable effective strategies and efficient use of resources;
- Help develop programs and inform decisions at the local, state and federal levels of government; and
- Support community collaborative efforts.

HIT is a foundational tool for achieving high impact changes in the health system. HIT enables health care providers to better manage patient care through secure use and sharing of health information. Data collected through this survey contributes to useful physician clinic information that enhances market transparency and improves health care quality for Minnesotans.

Results will be used for public reporting by MDH and MN Community Measurement on mnhealthscores.org.

This survey is sent to all medical group primary contacts of ambulatory clinics registered with MN Community Measurement. The survey should be completed by each unique clinic site as registered in the MN Community Measurement data portal. Due to the variety of topics covered, survey respondents may need to coordinate with others at the clinic site to accurately answer all questions.

If you have multiple clinic locations that all use the same EHR platform, there is the ability to request response duplication across other sites at the survey’s end. For assistance with taking the survey or other questions, please contact MN Community Measurement at support@mncm.org.
SURVEY INSTRUCTIONS

Step 1: Make sure you are the appropriate person to answer the survey. The appropriate survey respondent is someone who works at the clinic site at least part-time and has knowledge of both clinic operations and HIT. If you do not think you are the right person you should forward the survey link to the appropriate staff and exit the survey.

Step 2: Use the paper survey tool attached to answer the questions before accessing the web survey. This is recommended as: 1) it will speed the time you spend entering the responses into the web, 2) you may need to get input from others in your organization and this can help, 3) because we need to allow for multiple entries from a single point of contact, you cannot leave and "resume" the survey on-line. THE WEB SURVEY NEEDS TO BE ENTERED IN ONE SITTING.

Step 3: Look up your MNCM Clinic ID. If you do not know your MNCM Clinic ID, log on to the MN Community Measurement portal at https://data.mncm.org/login. Then click on the "Clinics" tab to access the MNCM Clinic ID; it will be listed under the "MNCM ID" column for each clinic. (Do not enter the MNCM Medical Group ID)

Step 4: Complete the web survey answering the questions on behalf of your clinic site from your paper copy. Use the PREV and NEXT buttons at the bottom of each page to move through the survey.

There is the ability at the end of the survey to request the responses be duplicated to another clinic site(s) if the processes of care and EHR platform are identical. You will need to attest and provide the other clinic MNCM site IDs.

When you have entered all of your responses, click DONE at the end of the survey.

Field testing found that clinics without electronic health records took an average of less than 10 minutes to complete the survey. Clinics with electronic health records averaged about 20-30 minutes to complete.

QUESTIONS? If at any time you have questions, please contact MN Community Measurement at 612-746-4522 or e-mail at support@mncm.org.
If you need your MN Community Measurement (MNCM) Clinic ID, log on to https://data.mncm.org/login and click on "CLINICS" tab. The ID will be listed under the "MNCM ID" column for each clinic.

**1. Clinic Site**

<table>
<thead>
<tr>
<th>Clinic site name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MNCM Clinic ID:</td>
<td></td>
</tr>
</tbody>
</table>

**2. Who is completing this survey?**

<table>
<thead>
<tr>
<th>Your name:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Your title:</td>
<td></td>
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<tr>
<td>Your e-mail:</td>
<td></td>
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<tr>
<td>Your phone number:</td>
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</tbody>
</table>
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.

source

3. Which statement best describes your clinic’s electronic health record (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 clinic staff and providers
- We have an EHR installed in all (more than 90%) areas of our clinic
EHR Implementation, continued

**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.

**source**

4. Was your clinic’s **FIRST** EHR system live on/before January 1, 2013?

- [ ] Yes
- [ ] No
- [ ] Not sure
5. On what date did/will your clinic go live with its first EHR system?
Month: 

6. Day: 

7. Year: 
DEFINTION: A certified EHR meets the adopted standards and certification criteria to help providers and hospitals achieve the 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. source

8. Does your clinic currently use a 2014 ONC-certified EHR system with the necessary components to attest?
   - Yes
   - No
   - Not sure

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

   [Vendor list]

   If not listed, what is your system?

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
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, check for allergies or interactions with other medications, and warn the provider about potential problems. source

11. Does your clinic have a Computerized Provider Order Entry (CPOE) function?

- Yes, our clinic currently has and uses CPOE for some or all provider orders
- Yes, our clinic has CPOE function but this function is not in use or turned off
- No, our clinic does not have CPOE
12. What percentage of provider orders (medication orders, lab and diagnostic test orders) are completed using the CPOE function?

- 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 to using CPOE does your clinic face? (select all that apply)

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

Other (please specify)
Clinical Decision Support

**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. [source]

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)

<table>
<thead>
<tr>
<th>Tool</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>Automated reminders for missing labs and tests (e.g., overdue HbA1c labs for diabetic patients)</td>
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<tr>
<td>Chronic disease care plans and flow sheets</td>
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<tr>
<td>Clinical guidelines based on patient problems list, gender, and age</td>
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<tr>
<td>High tech diagnostic imaging (HTDI) decision support tools</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Medication guides/alerts</td>
<td>[ ]</td>
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<td>[ ]</td>
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</tr>
<tr>
<td>Patient-specific or condition-specific reminders (e.g., foot exams for diabetic patients)</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Preventive care services reminders (e.g., mammograms for women who are not current with screening)</td>
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<td>[ ]</td>
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<td>[ ]</td>
</tr>
</tbody>
</table>

15. What barriers to using tools for clinical decision making at the point of care does your clinic face? (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 applicable - There are no barriers to using the EHR's clinical decision making tools
- [ ] Not sure

Other (please specify)
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 education resources when appropriate (e.g., tobacco cessation resources for smokers)?

- Yes
- No
- Not sure
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 source

19. Does your clinic document the existence of a patient’s advance directive in your EHR?

- Yes
- No
- Not sure
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?

- Electronically accessible - stored in readily accessible/consistent part of the EHR
- 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
- 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)

<table>
<thead>
<tr>
<th>Function</th>
<th>80-100% of encounters</th>
<th>50-79% of encounters</th>
<th>25-49% of encounters</th>
<th>Less than 25% of encounters</th>
<th>Function not in use / Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
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<tr>
<td>Weight</td>
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<tr>
<td>Blood pressure</td>
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<tr>
<td>Body Mass Index (BMI)</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Information</th>
<th>80-100% of patients</th>
<th>50-79% of patients</th>
<th>25-49% of patients</th>
<th>Less than 25% of patients</th>
<th>Not collected / Not able to collect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
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<tr>
<td>Hispanic Ethnicity</td>
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<tr>
<td>Country of Origin</td>
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<tr>
<td>Preferred Language</td>
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<tr>
<td>Insurance Type</td>
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</tbody>
</table>
24. Does your clinic’s EHR system have the ability to capture and report more than one race per patient?

- Yes
- No
- Not sure

**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”.

Source: Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement, Institute of Medicine, 2009.

25. Does your clinic’s EHR system have the ability to capture and report granular (detailed) ethnicity information?

- Yes
- No
- Not sure
26. For approximately what percent of patients are you capturing granular (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 EHR able to generate at least one report that lists patients by a specific condition (e.g., a disease registry)?

- Yes
- No
- Not sure
28. For which diseases do you currently generate reports? (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:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define permissions for who should have access to their health record and under what circumstances</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Express preferences regarding how and under what circumstances their health information may be shared with others</td>
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<tr>
<td>Authorize the release of their health information to another provider or third party</td>
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</tbody>
</table>

30. Does your clinic’s 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 process?

- [ ] Yes
- [ ] No
- [ ] Not sure

32. How does your clinic track patient consents?

- [ ] Consents are tracked electronically (e.g., 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)
33. Please indicate the extent to which you agree that your clinic’s EHR system has helped providers in your clinic . . .

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Agree somewhat</th>
<th>Disagree</th>
<th>Not sure or not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be alerted to critical lab values</td>
<td></td>
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<tr>
<td>Be alerted to potential medication errors</td>
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<tr>
<td>Be reminded to provide preventive care (e.g., vaccine)</td>
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<tr>
<td>Enhance patient care in your clinic</td>
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<tr>
<td>Identify needed lab tests (e.g., HbA1c or LDL)</td>
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<tr>
<td>Order fewer tests due to better availability of other lab results</td>
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<tr>
<td>Order more on-formulary drugs (e.g., as opposed to off-formulary drugs)</td>
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<tr>
<td>Provide care that meets clinical guidelines for patients with chronic disease</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>To create benchmarks or develop clinical priorities</td>
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<td>To share data with providers</td>
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<tr>
<td>To set goals around clinical guidelines</td>
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<tr>
<td>To support professional development activities (e.g., certifications)</td>
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</tbody>
</table>
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 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
- 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 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

37. Does your clinic use your EHR to collect and submit quality measures to an outside organization (e.g., Centers for Medicare and Medicaid Services, Physician Quality Reporting System, or MN 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 (HIE)

DEFINITION: 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. source

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)?

- 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
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 require referral or transition
- 25-49% of patients who require referral or transition
- Less than 25% of patients who require referral or transition
- Not sure
DEFINITION: Health Information Exchange (HIE) means the electronic transmission of clinical health-related information between organizations according to nationally recognized standards. Health information exchange does not include paper, mail, phone, fax, or non-secure email. - If you "electronically send" electronic health information, you are using your EHR to transmit data to another entity. - If you "electronically receive" electronic health information, your EHR updates information from an external source. source

40. For each of the following types of health providers/organizations, indicate if:
1) your clinic needs to send and/or receive clinical health information with each organization,
2a-2e) then for each type of organization with which you need to exchange, indicate what types of information you electronically exchange.
3) If you do not or cannot electronically transmit, select the right-most column.
Select all types of information that apply for each provider.

<table>
<thead>
<tr>
<th>Clinical/ambulatory providers (outside system/unaffiliated)</th>
<th>1. Your clinic has a need to send/receive</th>
<th>2a. Summary of Care record</th>
<th>2b. Lab results</th>
<th>2c. Medication History</th>
<th>2d. Immunizations</th>
<th>2e. Other</th>
<th>3. We do not/cannot electronically transmit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals (outside system/unaffiliated)</td>
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<tr>
<td>Local public health departments</td>
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<tr>
<td>Minnesota Department of Health</td>
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<tr>
<td>Home health agencies</td>
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<tr>
<td>Behavioral health providers (for mental health and substance use treatment)</td>
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<td>Nursing homes</td>
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<td>Long-term care and post-acute care other than nursing homes(e.g., rehab or assisted living)</td>
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<tr>
<td>Social service agencies/organizations</td>
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</table>
41. For each type of clinical information above 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.

<table>
<thead>
<tr>
<th>Information Type</th>
<th>Usually as a fax, PDF file, static document or scanned in</th>
<th>Usually as discrete standardized data (e.g., LOINC or SNOMED)</th>
<th>Usually as discrete data but not standardized (e.g., text or local code)</th>
<th>Not sure</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Summary of Care record</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>b. Lab Results</td>
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<tr>
<td>c. Medication History</td>
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<td></td>
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<tr>
<td>d. Immunizations</td>
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</tbody>
</table>

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

- Exchange capability built into your EHR (e.g., Care Everywhere in Epic)
- Exchange using a State-Certified HIE Service Provider (e.g., CHIC/HIE-Bridge, Eldermark Exchange, Emdeon, IOD, Relay Health, Surescripts, CenterX, MaxMD, etc.) See complete list at http://www.health.state.mn.us/divs/hs.utc/certif.html
- Interstate HIE and HealthWay/eHealth Exchange (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)
- We do not electronically exchange health information
- Do not know

Other (please specify)
43. 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

44. For each of the following types of clinical data reported to Minnesota Department of Health (MDH), indicate which are your clinic’s TOP THREE PRIORITIES for MDH to enable electronic exchange, including submission and/or response (electronic transfer from system to system, not including electronic fax or non-secure email). Select your top 3 priorities.

☐ Vital statistics (e.g., births, deaths)
☐ Newborn screening
☐ Birth defects
☐ Trauma, traumatic brain/spinal cord injury, stroke
☐ Immunization information (MIIC)
☐ Infectious disease surveillance
☐ Cancer surveillance system
☐ MDH’s public health lab
Other (please specify)

45. Describe what MDH can do to support your clinic’s process for submitting and/or receiving clinical data.
46. What are your greatest barriers related to secure HIE with outside organizations? (select all that apply)

- Capabilities of outside organizations to receive and send electronic data unknown
- Capacity of outside organizations to send and receive is limited or does not exist
- Competing priorities (e.g., ICD-10)
- HIPAA, privacy or legal concerns
- Inability of system to generate, send or receive electronic messages or transactions in standardized format
- Insufficient information on exchange options available
- Internet access does not support HIE
- Lack of access to technical support or expertise
- Our provider partners are not connected to our state-certified HIE vendor
- Subscription rates for exchange services are too high
- Unclear value of investment or return on investment
- Not applicable - there are no barriers related to secure information exchange with outside organizations

Other (please specify)
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.

47. Does your clinic 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 1-5 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 within the next 5 years

48. Please indicate how much the following barriers impact your clinic's EHR implementation status: (answer for each selection)

<table>
<thead>
<tr>
<th>Barrier</th>
<th>significant barrier</th>
<th>somewhat of a barrier</th>
<th>not a barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to secure financing for an EHR system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to high speed internet (e.g., broadband, cable)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequacy of training for you and your staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual cost of maintaining an EHR system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effort needed to select an EHR system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finding an EHR system that meets your practice's needs</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Loss of productivity during the transition to an EHR system</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Reaching consensus within the practice to select an EHR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reliability of the system (e.g., EHR down or unavailable when needed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resistance of your practice to change work habits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- Staff to lead the implementation of the EHR
- Staff to help design, customize, and/or maintain an EHR for use in our clinic
- Staff to get the EHR ready for use (entering orders, patient information, etc.)
- Computer/IT personnel
- Informatics nurses, clinicians, or other staff
- Trainers

Other (please specify)
50. 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 patient's health information online)
- Download (patient or authorized representative can download patient's health information to a physical electronic media (USB, CD) or as PDF document)
- Transmission (patient or authorized representative can transmit patient's 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

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

51. Does your clinic offer an online portal?

- Yes, we have a patient portal
- No, we don't have a patient portal
- Not sure
52. Indicate the features or functions 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 clinic visit summary
- Access to care plans
- Access to allergies list
- Access to diagnosis/problem list
- Access to providers’ progress notes/documentation

Other (please specify)

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 networks 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. [source](#)

53. Indicate other features or functionalities your clinic offers through the patient portal or other methods. (select all that apply)

- 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/email

Other (please specify)
### Telemedicine

**DEFINITION:** Telemedicine/Telehealth is the use of telecommunications technologies (e.g., phones, email, 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](http://www.americantelemed.org))

54. Indicate which of the following telemedicine/telehealth activities are conducted at your clinic. (answer for each selection)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Originating site: the patient is physically at your clinic at the time the service occurs via a telecommunications system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
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<td></td>
</tr>
<tr>
<td>Real-time teleconsultations: provider-to-provider or provider-to-patient consultation at a distance using real-time videoconferencing</td>
<td></td>
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</tr>
<tr>
<td>Store-and-forward teleconsultations: provider-to-provider or provider-to-patient consultation at a distance by storing digital content and then transmitting the files at another time (i.e., not real-time)</td>
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<td></td>
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</tr>
<tr>
<td>Remote patient monitoring: Patients use home-based or mobile medical devices to perform routine tests and send the test data to a healthcare professional in real time (e.g., blood glucose or heart ECG while the patient is not at the clinic location)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
55. 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 health/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)

[ ]
56. What barriers to using telemedicine/telehealth services does your clinic face? (select any that apply)

- Cost of equipment
- Cost to provide (including hosting and staff costs)
- Insufficient bandwidth (infrastructure and/or internet connectivity issues)
- Lack of staff expertise/training
- Lack of staff support
- No identified need or demand for telemedicine/telehealth services
- Patients are dissatisfied with telemedicine/telehealth services
- Physicians/other clinicians not available to provide services
- Reimbursement from payors does not cover cost
- Not applicable/we have no barriers

Other (please specify)
57. Which statement best describes how your patients most often receive a prescription for NON-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. Which statement best describes how your patients most often receive a prescription for 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)
**E-Prescribing, continued**

**Definition:** E-Prescribing is sending prescriptions electronically from a provider's system to a pharmacy without an interim step from the staff or patient.

**59. Estimate the percent of prescriptions that are e-prescribed by your clinic. (select one for each row)**

<table>
<thead>
<tr>
<th>For prescriptions that DO NOT include controlled substances</th>
<th>80-100% of prescriptions</th>
<th>50-79% of prescriptions</th>
<th>25-49% of prescriptions</th>
<th>Less than 25% of prescriptions</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>For prescriptions that include controlled substances</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**60. Are providers electronically alerted to any of the following AT THE POINT OF E-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 barriers to e-prescribing does your clinic face? (select all that apply)

- Capabilities of pharmacy to receive and send electronic data unknown
- Capability of the vendor software to e-prescribe
- Competing priorities
- Currently incapable of sending prescriptions for controlled substances
- HIPAA, privacy or legal concerns
- Inability of system to generate, receive or send electronic messages for transactions in standardized format
- Insufficient information available on e-prescribing options
- Internet access does not support e-prescribing
- Lack of access to technical support or expertise
- Pharmacy does not receive e-prescriptions
- Provider preference to write prescriptions by hand
- Unclear value of return on investment
- Not applicable - there are no barriers to e-prescribing

Other (please specify)
62. For what percent of patients does your clinic routinely check insurance eligibility electronically, either using the EHR or another electronic method?

- 80-100% of patients
- 50-79% of patients
- 25-49% of patients
- Less than 25% of patients
- We do not have this function or it is turned off
- Not sure

63. For what percent of patients does your clinic routinely file claims electronically for patients, either using the EHR or another electronic method?

- 80-100% of patients
- 50-79% of patients
- 25-49% of patients
- Less than 25% of patients
- We do not have this function or it is turned off
- Not sure

64. For what percent of claims does your clinic receive electronic remittance advices (ERA)?

- 80-100% of claims
- 50-79% of claims
- 25-49% of claims
- Less than 25% of claims
- We do not have this function or it is turned off
- Not sure
65. For what percent of claims does your clinic receive electronic acknowledgements of claim submissions?

- 80-100% of claims
- 50-79% of claims
- 25-49% of claims
- For less than 25% of claims
- No, we do not have this function or it is turned off
- Not sure
The responses contained in this survey may be the same for other clinic sites within your medical group. If those sites qualify, MNCM can duplicate the responses from this survey to those clinic sites based on the following eligibility:

1) the same EHR technology systems are installed in ALL of your clinic sites. If not, a separate HIT survey must be completed for each site with a different system.
2) identical processes of care exist across ALL clinic sites. Again, if not, a separate HIT survey must be completed for each site with different processes.

66. Please indicate your attestation by checking the boxes below:

[ ] I attest that all clinics in my medical group that I am requesting response duplication for have the same EHR technology and functions.

[ ] I attest that all clinics in my medical group that I am requesting response duplication have the same processes of care.

67. Requested Clinic Sites: You must enter the MNCM Clinic ID for each of the OTHER sites you want survey response duplication applied. To obtain any MNCM Clinic ID, please log into https://data/mncm.org/login and click on "Clinics" tab.

Site 1
Site 2
Site 3
Site 4
Site 5
Site 6
Site 7
Site 8
Site 9
Site 10

68. Additional Clinic Sites - If you have more than 10 sites that qualify for the duplication process, please list the additional MNCM Clinic IDs here.
Thank You

You have completed the 2015 HIT Ambulatory Clinic Survey! Please click the "Done" button on the bottom of this page to submit your survey responses to MNCM.

VALIDATION
MN Community Measurement will contact clinics who are selected for validation audits starting April 24, 2015.

If you have further questions about the HIT Ambulatory Clinic Survey, please contact MN Community Measurement by phone at (612) 746-4522 or by email at support@mncm.org.