Health Information Technology Survey

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

This survey is being sent to all primary contacts for ambulatory clinics registered with MN Community Measurement. The Minnesota Statewide Quality Reporting and Measurement Initiative (Minnesota Rules, Chapter 4654) requires that all physician clinics complete this survey between the dates of February 15, 2010 and March 15, 2010.

The survey should be completed by yourself or another person on behalf of each unique clinic site as registered in the MN Community Measurement data portal. To answer the survey, the appropriate respondent should:

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

MN Community Measurement has facilitated the development of the HIT Ambulatory Clinic Survey with input from members of the community. The survey was designed to collect information for multiple stakeholders to minimize the number of surveys required for completion by medical groups and clinics.

The results from the survey:
1. Will fulfill state requirements for the Minnesota Statewide Quality Reporting and Measurement initiative (Minnesota Rules, Chapter 4654)
2. Will be used for public reporting for MN Community Measurement on mnhealthscores.org
3. May be used by organizations (such as the MN Department of Health or the Regional Extension Center) for baseline assessment of Minnesota's HIT adoption and meaningful use of HIT
4. May be used by health plans for HIT related programs or incentives

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 clinic site and has knowledge of both clinic 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: Look up your MNCM Clinic ID.

If you do not know your MNCM Clinic ID, log on to the MN Community Measurement portal at data.mncm.org.

Step 3: Take the survey answering the questions on behalf of your clinic site. Use the PREV and NEXT buttons at the bottom of each page to move through the survey. When you have completed your responses, click DONE at the end of the survey.

Need to stop and come back? The computer you are using can be used to complete one survey. You can answer some questions, exit the survey, and return to complete the survey at a later time. Once you
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 clinicians and staff across more than one health care organization.

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

If your clinic 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.

CMS will be distributing incentives in future years to Medicare and Medicaid providers who can demonstrate "meaningful use" of health information technology and electronic health records.

All practicing physicians are potentially eligible for Medicare incentives for meaningful use of Health Information Technology. To be eligible for Medicaid incentives, physicians and advance practice nurses must have a patient mix with 30% or more Medicaid patients (pediatricians need 20% of their patients to be on Medicaid).

Many of the questions on this survey follow the Medicare and Medicaid requirements. Your clinic 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 Brenda Paul at paul@mncm.org.

If you need your MN Community Measurement Clinic ID, log on to data.mncm.org and click on "CLINIC SITES."

1. Please supply your clinic site name.
2. Enter your MN Community Measurement Clinic ID
3. Survey responder/survey contact
   Who is completing this survey?
   Your name:
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 clinicians and staff across more than one health care organization.

1. Which statement best describes your clinic'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 clinic staff and providers
   - We have an EHR installed and in all (more than 90%) areas of our clinic

Implementation Details

DEFINITIONS

Clinical staff: Any employee who performs medical duties including nurses, LPNs, physical therapists, etc.

Providers: Physicians, physician assistants, nurse midwives, and nurse practitioners

1. Estimated number of CLINICAL STAFF currently using your EHR system routinely.
   - Not sure
   - Less than 25% of all clinical staff
   - 25-50% of all clinical staff
   - 51-90% of all clinical staff
   - 91-100% of all clinical staff

2. Estimated number of PROVIDERS (physicians and other providers) currently using your EHR system routinely.
   - Not sure
   - Less than 25% of all providers
   - 25-50% of all providers
   - 51-90% of all providers
   - 91-100% of all providers

3. 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 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

### EHR Primary Questions

This page addresses questions about a clinic'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 clinicians and staff across more than one health care organization.

1. Please select your clinic's EHR system from the drop down list below:

2. What year did your clinic COMPLETE installation of your current EHR system?

   - 2005 or earlier
   - 2006
   - 2007
   - 2008
   - 2009
   - 2010
   - Installation in progress but not complete

### Non-CCHIT EHR System details

This page asks about EHR systems that are not certified and 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 clinicians and staff across more than one health care organization.

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

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

3. Does your EHR have the ability to track and record...(responses YES, NO, NOT SURE)

   - Providers associated with a patient encounter?
   - Clinical documentation and notes (e.g. progress notes)
1. Does your clinic have a Computerized Provider Order Entry (CPOE) function?
   - 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
   - No, our clinic 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)?
   - Less than 25% of all provider orders
   - 25-49% of all provider orders
   - 50-79% of all provider orders
   - 80-100% of all provider orders
   - Not applicable - We do not use CPOE or the function is turned off

3. What challenges does your clinic face in using CPOE? (select all that apply)
   - Some providers 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.)
   - Not applicable - there are no challenges to using CPOE
   - Other (please specify)

DEFINITION: Computerized Provider Order Entry (CPOE) is a computer application that allows a physician'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 compares the order against standards for dosing, checks for allergies or interactions with other medications, and warns the physician about potential problems.
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 clinic’s providers and staff access **DURING** a patient encounter?

<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>Clinical guidelines based on patient problem list, gender, and age</td>
<td>Used routinely</td>
<td>Used occasionally</td>
<td>Not available</td>
<td>Function turned off / Not in use</td>
</tr>
<tr>
<td>High tech diagnostic imaging decision support tools</td>
<td>Used routinely</td>
<td>Used occasionally</td>
<td>Not available</td>
<td>Function turned off / Not in use</td>
</tr>
<tr>
<td>Medication guides/alerts</td>
<td>Used routinely</td>
<td>Used occasionally</td>
<td>Not available</td>
<td>Function turned off / Not in use</td>
</tr>
<tr>
<td>Chronic care plans and flow sheets</td>
<td>Used routinely</td>
<td>Used occasionally</td>
<td>Not available</td>
<td>Function turned off / Not in use</td>
</tr>
<tr>
<td>Patient specific or condition specific reminders (e.g. foot exams for diabetic patients)</td>
<td>Used routinely</td>
<td>Used occasionally</td>
<td>Not available</td>
<td>Function turned off / Not in use</td>
</tr>
<tr>
<td>Preventive care services due (e.g. mammograms for women who are not current with screening)</td>
<td>Used routinely</td>
<td>Used occasionally</td>
<td>Not available</td>
<td>Function turned off / Not in use</td>
</tr>
<tr>
<td>Automated reminders for missing labs and tests (e.g. overdue HbA1c labs)</td>
<td>Used routinely</td>
<td>Used occasionally</td>
<td>Not available</td>
<td>Function turned off / Not in use</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 provider training
- [ ] Requires resources to build/implement
- [ ] Requires a system upgrade
- [ ] Software not available
- [ ] Hardware issues (computers not available in all exam rooms, etc.)
EHR Follow-up Questions: Lab and Test Results

This page asks additional information about electronic storage of lab and diagnostic test results.

1. 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

2. Does your clinic incorporate lab test results (e.g. HbA1c or LDL 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, 50% or more of lab test results are recorded as structured data
   - Yes, fewer than 50% of lab test results are recorded as structured data
   - No
   - Not sure

EHR Follow-up Questions: Other EHR Functions

1. Does your clinic 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, 80% or more of our patients have at least one coded entry or indication in their problem list or "none indicated"
   - Yes, less than 80% of our patients have at least one entry or indication in their problem list or "none indicated"
   - No
   - Not sure

2. Does your clinic track and record vital signs using the EHR for the following:

   - Yes, for 80% or more of all patient encounters
   - Yes, for less than 80% of patient encounters
   - No, not collected with our EHR / Function not in use / Not sure

   Height

   - Yes, for 80% or more of all patient encounters
   - Yes, for less than 80% of patient encounters
   - No, not collected with our EHR / Function not in use / Not sure
<table>
<thead>
<tr>
<th>Measure</th>
<th>Yes, for 80% or more of all patient encounters</th>
<th>Yes, for less than 80% of patient encounters</th>
<th>No, not collected with our EHR / Function not in use / Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

3. Does your clinic plot and display growth charts for children ages 2-20 including Body Mass Index (BMI)?

- ☐ Yes, for 80% or more of patients aged 2-20
- ☐ Yes, for less than 80% of patients aged 2-20
- ☐ Yes, we have growth charts, but these charts do not plot BMI
- ☐ No, we do not have this function or it is turned off
- ☐ Not sure

4. Does your clinic track tobacco smoking using the EHR on patients 13 and older?

- ☐ Yes, 80% or more of patients 13 and older have "smoking status" recorded
- ☐ Yes, less than 80% of patients 13 and older have "smoking status" recorded
- ☐ No, we do not record smoking status in our EHR
- ☐ Not sure

5. Does your clinic provide patients with an electronic copy of their health information (including test results and medication lists) upon request? Electronic copies can be provided via patient portal, personal health records (PHR), e-mail, USB drive, CD, or other electronic media.

- ☐ Yes, usually provided within 48 hours of the request
- ☐ Yes, usually provided more than 48 hours after the request
- ☐ No, we do not have this capability or it is turned off
- ☐ Not sure

6. Does your clinic provide patients with electronic access to their health information (including lab results and medication lists) within 96 hours of the information being available to the provider?

- ☐ Yes, at least 10% of all unique patients are provided electronic access to health information within 96 hours of the information being available to the provider
- ☐ No, we do provide electronic access to health information but it takes longer than 96 hours
No, we do not provide patients electronic access to health information

7. Does your clinic provide clinical summaries for patients for each office visit?

DEFINITION: After-visit clinical summaries contain updated medication lists, lab and test orders, procedures, and instructions based on clinical discussions taking place during the visit.

- Yes, we provide clinical summaries for at least 80% of office visits
- Yes, we provide clinical summaries for less than 80% of office visits
- No, we do not have this function or it is turned off

8. Which phrase best describes your clinic's use of CARE PLANS?

DEFINITION: Care plans are written documents for certain chronic conditions requiring advanced management. Care plans are developed with the patient and guide care management by outlining risks, goals, prevention, and actions for treatment (e.g. an asthma action plan).

- 80% or more of patients requiring care coordination have a care plan in the EHR and are given a copy
- Less than 80% of patients requiring care coordination have a care plan given to them and/or saved in the EHR
- 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 are not able to identify patients who should have care plans
- We do not develop or use written care plans
- Other (please specify)

Privacy and Security

1. Does your clinic allow patients to set the following privacy standards:

<table>
<thead>
<tr>
<th>Definition</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>
</tr>
<tr>
<td>Express preferences regarding how and under what circumstances health information may be shared with others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorize the release of health information to another provider or third party</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Does your EHR limit users to see only the information they need - based on staff function or other criteria?

- Yes
- No
1. 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

2. How does your clinic 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

### Quality Improvement Functions for Population Management

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

<table>
<thead>
<tr>
<th>Function</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>To create benchmarks and clinical priorities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To share data with providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To set goals around clinical guidelines</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Does your clinic routinely identify and remind patients who are due for preventive care (e.g. colorectal cancer screenings, influenza vaccinations, etc.)?

- [ ] Yes, our organization routinely identifies and reminds 50% or more of patients of preventive care due
- [ ] Yes, our organization identifies and reminds less than 50% of patients of preventive care due
- [ ] No, our organization does not identify and remind patients of needed preventive care
- [ ] Not sure

3. Does your clinic routinely send patients reminders for needed follow-up care (e.g. follow-up appointments, scheduled procedures, etc.)?

- [ ] Yes, our organization routinely reminds 50% or more of patients of follow-up care
- [ ] Yes, our organization reminds less than 50% of patients of follow-up care
- [ ] No, we do not send reminders to patients for follow-up care
- [ ] Not sure

4. Does your clinic use the EHR to collect and submit quality measures to an outside organization (e.g. CMS, PQRI or MN Community Measurement)?

- [ ] Yes
- [ ] No
- [ ] Not sure
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 clinic capture in the EHR?

<table>
<thead>
<tr>
<th>Demographic Information</th>
<th>Available for 80% or more of patients</th>
<th>Available for less than 80% of patients</th>
<th>Not collected / Not able to collect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Information available</td>
<td>Information available</td>
<td>Not collected / Not able to collect</td>
</tr>
<tr>
<td>Age or Date of Birth</td>
<td>Information available</td>
<td>Information available</td>
<td>Not collected / Not able to collect</td>
</tr>
<tr>
<td>Race</td>
<td>Information available</td>
<td>Information available</td>
<td>Not collected / Not able to collect</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Information available</td>
<td>Information available</td>
<td>Not collected / Not able to collect</td>
</tr>
<tr>
<td>Country of origin</td>
<td>Information available</td>
<td>Information available</td>
<td>Not collected / Not able to collect</td>
</tr>
<tr>
<td>Primary language</td>
<td>Information available</td>
<td>Information available</td>
<td>Not collected / Not able to collect</td>
</tr>
<tr>
<td>Insurance type</td>
<td>Information available</td>
<td>Information available</td>
<td>Not collected / Not able to collect</td>
</tr>
</tbody>
</table>

6. Is your clinic able to generate at least one report that lists patients by a specific condition (i.e. a disease registry)?

Yes
No
Not sure

7. If you are able to generate reports by condition, for which diseases 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)

<table>
<thead>
<tr>
<th>Information Exchange Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does your clinic routinely check insurance eligibility electronically?</td>
</tr>
<tr>
<td>- Yes, for 80% or more of patients</td>
</tr>
<tr>
<td>- Yes, for less than 80% of patients</td>
</tr>
<tr>
<td>- No, we do not have this function or it is turned off</td>
</tr>
<tr>
<td>- Not sure</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Patients</th>
<th>Providers (outside of system)</th>
</tr>
</thead>
<tbody>
<tr>
<td>We routinely SEND electronic data from the EHR</td>
<td>We routinely RECEIVE electronic data from this entity</td>
</tr>
<tr>
<td>We do not routinely send/receive electronic data with this entity (more likely to fax, call, e-mail or print)</td>
<td>We do not routinely send/receive electronic data with this entity (more likely to fax, call, e-mail or print)</td>
</tr>
</tbody>
</table>
4. Does your clinic provide an electronic summary care record for patients requiring transition (transfer of care from the clinic to an inpatient, outpatient, office or other setting) of care or a referral (a provider-initiated referral to another provider)?

<table>
<thead>
<tr>
<th>Setting</th>
<th>Routinely Send from EHR</th>
<th>Routinely Receive from Entity</th>
<th>Do Not Routinely Send/Receive with Entity</th>
</tr>
</thead>
<tbody>
<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>
<tr>
<td>State immunization registries</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Electronic record locator sharing pool</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Department of Health (for required reportable diseases)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Yes, for 80% or more of care transitions and referrals
☐ Yes, for less than 80% of care transitions and referrals
☐ No, we do not have this function or it is turned off
☐ Not sure

5. Medical groups and clinics may subscribe to outside services to facilitate health information exchange across organizations. Does your clinic use any of the following: (select all that apply)
☐ We have a direct agreement with at least one other clinic/hospital/health system
☐ We use a vendor or intermediary exchange service (e.g. RxHub)
☐ We use a non-profit Health Information Organization (e.g. MN-HIE or CHIC)
☐ Other (please specify)

6. What are your largest challenges related to secure information exchange with outside organizations? (select all that apply)
☐ Unclear value on investment (VOI) or return on investment (ROI)
☐ Subscriptron rates for exchange services are too high
☐ Competing priorities
☐ Access to technical support or expertise
☐ Insufficient information on options available
☐ HIPAA, privacy or legal concerns
☐ Other (please specify)

Telemedicine
DEFINITION: Telemedicine is the use of telecommunication 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.

1. Does your clinic use telemedicine services?
☐ Yes
☐ No
☐ Not sure

Telemedicine Barriers
1. What barriers to using telemedicine services does your clinic face? (select all that apply)
☐ Have not identified a need for telemedicine services
☐ Specialists/practitioners available
☐ Costs
☐ Lack of staff to support
Lack of staff expertise
Insufficient bandwidth
Hardware not available (computers, cameras, etc.)
NOT APPLICABLE - We use telemedicine / No barriers
Other (please specify)

### Telemedicine Follow-up Questions

**DEFINITION:** Telemedicine is the use of telecommunication 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.

1. **What types of telemedicine services does your clinic use?**

<table>
<thead>
<tr>
<th>Service</th>
<th>Use routinely</th>
<th>Use occasionally</th>
<th>Not used / Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide services to other providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To receive services from other providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To conduct visits with patients</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Do you use telemedicine for the following services?**

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance care planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral/mental health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imaging/radiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient monitoring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient encounters/office visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home care/hospice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other (please specify):**

**Medications and E-prescribing**

1. **Which statement best describes your clinic's prescribing practices:**

- Our providers order medications by entering prescription information into our EHR
Our providers order medications by entering prescription information into a computer system separate from our EHR.

Our providers order medications by entering prescriptions into a web-based application.

Our providers use prescription pads and paper to order medications.

**Stand Alone Medication Prescribing Systems**

1. What is the name of the electronic system your providers use to order medications?

   - Application name: [ ]
   - Version: [ ]
   - Year installed: [ ]

2. Is the system your providers use to order medications CCHIT certified?

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

3. Does the system your providers use to order medications have the ability to do the following:

   - Create prescription orders with enough information for a pharmacy to fill and dispense a prescription [ ]
   - Print or fax a prescription [ ]

**E-Prescribing**

1. Does your clinic generate and transmit permissible prescriptions electronically (also called e-Prescribing or eRx)? Permissible prescriptions are for non-controlled substances.

   - Yes, for 75% or more of all prescriptions [ ]
   - Yes, for less than 75% of all prescriptions [ ]
   - No, we do not have this function or it is turned off [ ]
   - Not sure [ ]

2. Does your clinic use an electronic prescription intermediary (e.g. Surescripts)? An electronic prescription intermediary is an e-prescribing network that supports sending, transferring, and receiving prescription information between pharmacies, prescribers, and health plans.

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

3. Does your clinic have and maintain an active medication list for patients (including over-the-counter medications)?
4. Does your clinic maintain an active medication allergy list for patients?
- Yes, for 80% or more of patients
- Yes, for less than 80% of patients
- No, we do not have this function or it is turned off
- Not sure

5. When providers are using your EHR or other electronic system to order medications, are they alerted to any of the following AT THE POINT OF PRESCRIBING (select all that apply):
- Potential drug-drug interactions
- Potential drug-allergy interactions
- Patient-specific formulary information
- Generic alternatives
- Cost comparison of medications
- Not applicable - our electronic systems do not alert providers to any of the above

6. Does your clinic perform medication reconciliation at every relevant patient encounter or transition of care? Medication reconciliation alerts providers in real-time to potential administration errors (e.g. wrong patient, wrong drug, wrong dose, wrong route and wrong time).
- Yes, for 80% or more of transitions and referrals
- Yes, for less than 80% of transitions and referrals
- No, we do not have this function or it is turned off
- Not sure

**Clinics 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 clinicians and staff across more than one health care organization.

1. 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 1-3 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

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

DEFINITION: Computerized Provider Order Entry (CPOE) is a computer application that allows a physician'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 compares the order against standards for dosing, checks for allergies or interactions with other medications, and warns the physician about potential problems.

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
No, our clinic does not have CPOE

3. Does your clinic use an electronic system to create and send prescriptions (also called e-prescribing or e-Rx)?

Yes
No
Not sure

4. Please identify if the following barriers impact your clinic's EHR implementation status:

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Significant barrier</th>
<th>Somewhat of a barrier</th>
<th>Not a barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost to acquire</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Return-on-investment concerns</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Physician support</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Non-physician provider support</td>
<td></td>
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<tr>
<td>Staff support</td>
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<td></td>
<td></td>
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<tr>
<td>Administration support</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Staff education and training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security/privacy concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Internal knowledge/technical resources

<table>
<thead>
<tr>
<th></th>
<th>Significant barrier</th>
<th>Somewhat of a barrier</th>
<th>Not a barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (please specify)</td>
<td></td>
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</tbody>
</table>

### On-line services

1. Does your clinic or organization offer any of the following on-line services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes, our clinic or organization offers this service</th>
<th>No, our clinic 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 clinic for an appointment)</td>
<td><img src="radio_button" alt="Yes" /></td>
<td><img src="radio_button" alt="No" /></td>
<td><img src="radio_button" alt="Not sure" /></td>
</tr>
<tr>
<td>On-line bill payment</td>
<td><img src="radio_button" alt="Yes" /></td>
<td><img src="radio_button" alt="No" /></td>
<td><img src="radio_button" alt="Not sure" /></td>
</tr>
<tr>
<td>E-visits (scheduled time for provider-patient interaction via electronic medium such as e-mail or Internet)</td>
<td><img src="radio_button" alt="Yes" /></td>
<td><img src="radio_button" alt="No" /></td>
<td><img src="radio_button" alt="Not sure" /></td>
</tr>
<tr>
<td>Secure e-mail for communication between providers and patients</td>
<td><img src="radio_button" alt="Yes" /></td>
<td><img src="radio_button" alt="No" /></td>
<td><img src="radio_button" alt="Not sure" /></td>
</tr>
<tr>
<td>Electronic visit reminders</td>
<td><img src="radio_button" alt="Yes" /></td>
<td><img src="radio_button" alt="No" /></td>
<td><img src="radio_button" alt="Not sure" /></td>
</tr>
<tr>
<td>Blogs or on-line support groups</td>
<td><img src="radio_button" alt="Yes" /></td>
<td><img src="radio_button" alt="No" /></td>
<td><img src="radio_button" alt="Not sure" /></td>
</tr>
</tbody>
</table>

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

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

THANK YOU!
**Degree of Impact**

Relevance to Consumers, Employers and Payers

The U.S. Congress passed the American Recovery and Reinvestment Act (ARRA) in 2009. A section of this new law, called the Health Information Technology for Economic and Clinical Health (HITECH) Act, provides funds for the adoption and use of electronic health records (EHR’s) and health information technology (HIT). The HITECH act also will establish benchmarking and measurement of these technologies in health care settings.

Minnesota’s multi-stakeholder collaborative, the Minnesota E-Health Initiative, is not only implementing the HITECH pieces passed by the U.S. Congress with the MN Department of Health, but is also working to advise and implement several Minnesota legislated HIT initiatives including requirements for e-prescribing, EHR adoption, and electronic information exchange.

Currently, health information technology (HIT) is a measure reported at the clinic site level by MN Community Measurement on mnhealthscores.org for consumers.

**Degree of Improvability**

A considerable amount of time and resources at the Minnesota and national levels are being invested in the improvement of the EHR and HIT infrastructure. Incentive payments for providers are going to be available from CMS and Medicaid for demonstrating meaningful use during the next several years. In addition, Minnesota has set requirements for the use of e-prescribing technology.

**Degree of Inclusiveness**

This measure includes all physician staffed ambulatory clinic sites in Minnesota. It does not include other sites of care such as nursing homes or assisted living facilities. It also does not include hospital HIT use and adoption, although a separate hospital-based survey will be fielded by the Minnesota Hospital Association in 2010.

**Fit with National, Regional, and Local Priorities**

Many parties currently survey medical groups and clinics about HIT use and adoption. Health plans in Minnesota request this information from providers as well as other community groups. The combination of efforts that are currently in practice with the legislated requirements that aim to drive HIT adoption in health care settings makes this a priority area for measurement and alignment of existing community HIT surveys.

**Performance Variation**

Performance variation has been demonstrated with the 2008 HIT survey conducted by MN Community Measurement. The survey results show wide variation in the use and adoption of certain aspects of EHR’s and HIT at the clinic site level in Minnesota.

**Existing Measures at a National and Local Level**

Several organizations have developed and fielded HIT and EHR surveys in the past. Most were reviewed by MN Community Measurement during the survey development process. The surveys most referenced during the workgroup process were as follows:

- Stratis Health’s Electronic Health Record (EHR) Landscape Survey
- Commonwealth Fund’s National Survey of Physicians on Practice Experience (considered one of the gold standards in health information technology surveys for providers and ambulatory care settings)
- The National Ambulatory Medical Care Survey (NAMCS) – also considered a gold standard
| **New Measure Development** | The primary aim of the technical advisory workgroup development process was to consolidate the different needs for similar information amongst diverse stakeholders into one tool in an effort to minimize survey burden on ambulatory clinics. In addition, the workgroup sought to develop a survey that took into account the changing landscape of EHR and HIT use to include concepts of meaningful use. The approach to develop the survey began by listing community stakeholders with an interest in HIT surveying, the questions that each stakeholder needed to fulfill their organizations’ objectives, and an attempt to identify concepts that are still yet to be fully developed at a national level. To inform the discussion, workgroup members included health plans, providers, the Minnesota Department of Health, the Minnesota Department of Human Services, members from the Minnesota e-Health Initiative, and the Regional Extension Center in Minnesota.

The survey development process went through extensive survey draft reviews, testing of the tool for validity and reliability of results, discussion about feasibility and implementation of the survey instrument, and an independent review by an epidemiologist with experience developing and fielding surveys on EHR use for Stratis Health. |
| **Enhance the patient/provider relationship** | Health information technology is believed by many as having a great potential to alter the delivery of health care services. It demonstrates valuable safety features (medication interaction alerts and clinical decision support tools) and opportunities for providers to use retrospective data for prospective medical care (prevention reminders and follow-up care). A survey that endeavors to determine if a medical group is using EHR technology meaningfully, is attempting to answer questions about the effectiveness of this tool in the care of patients. |
| **Considerations for Recommendation** | The technical advisory workgroup recommended that the MN Ambulatory Care HIT Survey be an online instrument. The survey was recommended to be e-mailed to the primary contact identified by clinics registered with MN Community Measurement. The survey was to be answered ideally by a person who: a) worked at the physical clinic location; b) has knowledge of clinic operations; and c) has knowledge of clinic health information technology systems.

The survey was reviewed by the Measurement and Reporting Committee at MN Community Measurement and subsequently approved by the Board of Directors in February of 2010. |