2011 MN HEALTH INFORMATION TECHNOLOGY (HIT) AMBULATORY CLINIC SURVEY

SYNOPSIS OF THE 2011 HIT SURVEY FOR MN CLINICS

February 2011

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

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

FOR CLINICS WITH EHRs

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

- Meaningful Use – page 4 of the survey
- Survey Respondent – page 5
- EHR Implementation and Implementation Details – pages 6 and 7
- EHR Primary Questions on page 8 – or EHR System Details on page 9
- Computerized Provider Order Entry (CPOE) – page 10
- Clinical Decision Support Tools – page 11
- Lab and Test Results – page 12
- Health Information Tracking – page 13
- Patient Access to Health Information – page 14
- Patient-Specific Health Information: Education and Care Plans – page 15
- Privacy and Security – page 16
- Patient Specific Information: Consents and Preferences – page 17
- Quality Improvement – page 18
- Disease Registries – page 19
- Information Exchange – pages 20 and 21
- Transfers and Care Transitions – page 22
- Telemedicine / Telemedicine Follow-up Questions / Telemedicine Barriers – pages 23-25
- E-Prescribing – pages 26-28
- On-line Services – page 30

FOR CLINICS WITHOUT EHRs

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

- Meaningful Use – page 4 of the survey
- Survey Respondent – page 5
- EHR Implementation – page 6
- HIT Info from Clinics without an EHR – page 29
- On-line Services – page 30
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, 2011 and March 15, 2011.

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

If you have multiple clinic locations and would like assistance in taking the survey or duplicating responses across more than one location, please contact Brenda Paul for assistance at paul@mncm.org.

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. Will 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
5. Published by MDH for the e-Health Initiative

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 click DONE at the very end of the survey you will not be able to re-enter the survey.

If you need to complete more than one survey using the same computer, contact Brenda Paul at paul@mncm.org.
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 or need more definition of terms, please contact MN Community Measurement at 612-454-2911 or e-mail support@mncm.org or Brenda Paul at paul@mncm.org.

PAGE 3: Electronic Health Record System Definition

DEFINITION OF EHR

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

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

PAGE 4: Meaningful Use of EHR’s

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

All eligible professionals are potentially eligible for Medicare financial incentives. 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.

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

<table>
<thead>
<tr>
<th>Planning to apply in 2011</th>
<th>Planning to apply in 2012</th>
<th>Planning to apply in 2013 or beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, under Medicare</td>
<td>Yes, under Medicare</td>
<td>Yes, under both Medicare and Medicaid</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

PAGE 5: Survey Respondent

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: __________________________
   Your title: __________________________
   Your e-mail: _________________________
   Your phone number: __________________

**PAGE 6: 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

**PAGE 7: 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.**
   - 80-100% of all clinical staff
   - 50-79% of all clinical staff
   - 25-49% of all clinical staff
   - Less than 25% of all clinical staff
   - Not sure

2. **Estimated number of PROVIDERS (physicians and other providers) currently using your EHR system routinely.**
   - 80-100% of all providers
   - 50-79% of all providers
   - 25-49% of all providers
   - Less than 25% of all providers
   - Not sure

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
4. Which EHR-related skills and/or roles are in greatest need in your organization? This includes adding new staff or developing the current staff. (select all that apply)
   - A person to lead the implementation of the EHR
   - People to help design, customize, and/or maintain an EHR for use in our clinic
   - People 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: _______________________________________________________

PAGE 8: 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. What year did your clinic COMPLETE installation of your current EHR system?
   - 2005 or earlier
   - 2006
   - 2007
   - 2008
   - 2009
   - 2010
   - 2011
   - Installation in progress but not complete

2. Please select your clinic's EHR system from the drop down list below: (SELECT FROM DROP DOWN BOX)

PAGE 9: EHR System Details

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

DEFINITION OF AN EHR: An EHR is an electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized 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...
   - Providers associated with a patient encounter?  
     - Yes
     - No
     - Not sure
   - Clinical documentation and notes (e.g. progress notes)
     - Yes
     - No
     - Not sure
   - Ordered and pending labs
     - Yes
     - No
     - Not sure
   - Ordered and pending diagnostic test results (e.g. mammography or other screening tests)
     - Yes
     - No
     - Not sure
   - Provider orders (including referrals)
     - Yes
     - No
     - Not sure
   - External documents (e.g. advanced directives or history & physicals)
     - Yes
     - No
     - Not sure
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PAGE 10: EHR Follow-up Questions: Computerized Provider Order Entry (CPOE)

This page asks more questions about your clinic’s use of an EHR’s order entry 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.

1. **Does your clinic have a Computerized 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)?**
   - [ ] 80-100% of all provider orders
   - [ ] 50-79% of all provider orders
   - [ ] 25-49% of all provider orders
   - [ ] Less than 25% of all provider orders
   - [ ] Not applicable - We do not use CPOE or the function is turned off
   - [ ] Not sure

3. **What challenges does your 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.)
   - [ ] Time too limited during patient encounter to use
   - [ ] Not applicable - there are no challenges to using CPOE
   - [ ] Other (please specify): ____________

PAGE 11: EHR Follow-up Questions: Clinical Decision Support Tools

This page asks more questions about your clinic’s use of decision support tools.

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

1. **What electronic clinical decision making support tools do your clinic’s providers and staff access DURING a patient encounter?**

<table>
<thead>
<tr>
<th>Clinical guidelines based on patient problem list, gender, and age</th>
<th>Used routinely</th>
<th>Used occasionally</th>
<th>Not available</th>
<th>Function turned off / Not in use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ]</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>High tech diagnostic imaging decision support tools</th>
<th>Used routinely</th>
<th>Used occasionally</th>
<th>Not available</th>
<th>Function turned off / Not in use</th>
</tr>
</thead>
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</table>

<table>
<thead>
<tr>
<th>Medication guides/alerts</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>
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<td>[ ]</td>
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<td>[ ]</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Chronic care plans and flow</th>
<th>Used routinely</th>
<th>Used occasionally</th>
<th>Not available</th>
<th>Function turned off / Not in use</th>
</tr>
</thead>
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<td>[ ]</td>
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</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.)
- Not applicable - There are no barriers to using the EHR’s clinical decision making tools
- Other (please specify): ____________________________

PAGE 12: 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, 80-100% lab test results are recorded as structured data
- Yes, 50-79% of lab test results are recorded as structured data
- Yes, 25-49% of lab test results are recorded as structured data
- Yes, less than 25% lab test results are recorded as structured data
- No, we do not record lab test results as structured data
- Not sure

PAGE 13: EHR Follow-up Questions: Health Information Tracking

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, for 80-100% of patients
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2. What percentage of your clinic’s encounters use the EHR to track and record vital signs:

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

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

- Yes, for 80-100% of patients
- Yes, for 50-79% of patients
- Yes, for 25-49% of patients
- Yes, for less than 25% of patients
- No, we do not have this function or it is turned off
- Not sure

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

- Yes, for 80-100% of patients aged 13+
- Yes, for 50-79% of patients aged 13+
- Yes, for 25-49% of patients aged 13+
- Yes, for less than 25% of patients
- No, we do not record smoking status in our EHR
- Not sure

PAGE 14: EHR Follow-up Questions: Patient Access to Health Information

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

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, for 80-100% of all encounters
- Yes, for 50-79% of all encounters
- Yes, for 25-49% of all encounters
- Yes, for less than 25% of all encounters
- No, we can provide clinical summaries, but it typically takes longer than 3 business days
- No, we do not use the EHR to provide clinical summaries
- No, we do not have this function or it is turned off
- Not sure

2. Does your clinic provide patients with electronic access to their health information (including lab results and medication lists) within 4 business days of the information being available to the provider?

- Yes, 80-100% of patients have electronic access within 4 days
- Yes, 50-79% of patients have access
- Yes, 25-49% of patients have access
- Yes, less than 25% of patients have access
3. Does your clinic provide patients with an electronic copy of their health information (including test results and medication lists) on request within 3 business days?

Electronic copies can be provided via patient portal, personal health records (PHR), email, USB drive, CD, or other electronic media.

- Yes, for 80-100% of requests
- Yes, for 50-79% of requests
- Yes, for 25-49% of requests
- Yes, for less than 25% of requests
- No, we provide information on request, but it typically takes longer than 3 business days
- No, we do not provide electronic copies of health information regularly
- No, we do not have this capability or it is turned off
- Not sure

4. How does your clinic provide patients with electronic copies of their health information:

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

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**PAGE 15: Patient-Specific Health Information: Education and Care Plans**

1. Do you use your EHR to identify patient-specific education resources (e.g. asthma action plans for asthma patients or tobacco cessation resources for smokers) when appropriate?

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

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

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

- We use the EHR to provide care plans to 80-100% of patients who need them
- We use the EHR to provide care plans to 50-79% of patients who need them
- We use the EHR to provide care plans to 25-49% of patients who need them
- We use the EHR to provide care plans to less than 25% of patients who need them
- We do not use our EHR to develop and save care plans - we use a paper or manual system to create, store and distribute
- We are do not/are not able to identify patients who should have care plans
- We do not develop or use written care plans
- Not sure
3. How does your clinic provide patients with electronic copies of their care plans:

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

PAGE 16: Privacy and Security

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

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>Express preferences regarding how and under what circumstances health information may be shared with others</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>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Does your organization conduct or review security risk analysis information and updates as necessary as part of your risk management processes?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PAGE 17: Patient Specific Information: Consents and Preferences

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 | ☐ | | |
| Other (please specify): ____________________________ |

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 | ☐ | | |
| Other (please specify): ____________________________ |

PAGE 18: 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>Activity</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 use your EHR to routinely identify and remind patients who are due for **preventive care** (e.g. colorectal cancer screenings, influenza vaccinations, etc.)?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80-100%</td>
<td>Yes, for 80-100% of patients</td>
</tr>
<tr>
<td>50-79%</td>
<td>Yes, for 50-79% of patients</td>
</tr>
<tr>
<td>25-49%</td>
<td>Yes, for 25-49% of patients</td>
</tr>
<tr>
<td>&lt;25%</td>
<td>Yes, for less than 25% of patients</td>
</tr>
<tr>
<td></td>
<td>No, we do not use the EHR to identify and remind patients of needed preventive care</td>
</tr>
<tr>
<td></td>
<td>Not sure</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80-100%</td>
<td>Yes, for 80-100% of patients</td>
</tr>
<tr>
<td>50-79%</td>
<td>Yes, for 50-79% of patients</td>
</tr>
<tr>
<td>25-49%</td>
<td>Yes, for 25-49% of patients</td>
</tr>
<tr>
<td>&lt;25%</td>
<td>Yes, for less than 25% of patients</td>
</tr>
<tr>
<td></td>
<td>No, we do not use our EHR to send reminders to patients for follow-up care</td>
</tr>
<tr>
<td></td>
<td>Not sure</td>
</tr>
</tbody>
</table>

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)?

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, we collect and submit quality measures using only our EHR</td>
</tr>
<tr>
<td>Yes, we collect and submit quality measures using our EHR and the patient's paper chart</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Not sure</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Information</th>
<th>Collected on less than 25% of patients</th>
<th>25-49% of patients</th>
<th>50-79% of patients</th>
<th>80-100% of patients</th>
<th>Not collected / Not able to collect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Age or Date of Birth</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Race</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Country of origin</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Primary language</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Insurance type</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

PAGE 19: Disease Registries

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

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Not sure</td>
</tr>
</tbody>
</table>
2. 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): _________________________________

---

PAGE 20: Information Exchange Activities

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>We routinely SEND electronic data from the EHR</th>
<th>We routinely RECEIVE electronic data from this entity</th>
<th>We do not routinely send/receive electronic data with this entity (more likely to fax, call, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Providers (outside of system)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hospitals (in system/affiliated)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hospitals (outside of system)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other care settings (nursing homes, assisted living, home health agencies)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

---

PAGE 21: Information Exchange Activities: Additional Health Exchange Questions
1. Has your clinic tested (at least one time) your EHR’s ability to send key electronic information like a problem list, medication list, or test results (information directly from the EHR to another entity without an interim step) to an outside provider or facility?
   - Yes
   - No
   - Not sure

2. Has your clinic tested (at least one time) your EHR’s ability to submit electronic data to an immunization registry?
   Note: Submitting electronic data includes only instances where data is sent directly from an EHR to the registry without an interim step.
   - Yes, using HL7 standards
   - Yes, using CVX code standards
   - Yes, but standard of transmission method unknown
   - No
   - Not sure

3. Has your clinic tested (at least one time) your EHR’s capacity to send public health data directly to the Department of Health or another public health agency?
   Note: Only include tests using electronic transmission of data directly from the EHR without an interim step.
   - Yes
   - No
   - Not sure

4. 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. Surescripts)
   - We use a non-profit Health Information Organization (e.g. MN-HIE or CHIC)
   - Other (please specify): ________________

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

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

PAGE 22: Transfers and Care Transitions

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

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

PAGE 23: 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

PAGE 24: 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
PAGE 25: 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:**
   - Use routinely
   - Use occasionally
   - Not used / Not available
   - To provide services to other providers
   - To receive services from other providers
   - To conduct visits with patients

2. **Do you use telemedicine for the following services:**
   - Yes
   - No
   - Not sure
   - Advance care planning
   - Behavioral/mental health
   - Imaging/radiology
   - Specialty care
   - Surgical follow-up
   - Patient monitoring
   - Patient encounters/office visits
   - Home care/hospice
   - Shared decision making
   - Other (please specify): ___________________________

PAGE 26: 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
   - Other (Please specify): ___________________________

PAGE 27: 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: __________________________

3. **Is the system your providers use to order medications certified?**
   - Yes
   - No
   - Not sure
3. **Does the system your providers use to order medications have the ability to do the following:**

<table>
<thead>
<tr>
<th>Create prescription orders with enough information for a pharmacy to fill and dispense a prescription</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print or fax a prescription</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. **Which statement best describes how your patients receive a prescription (other than a narcotic)?**

- Prescriptions are sent electronically from our system directly to a pharmacy without an interim step from the clinic staff or patient
- Prescriptions are created electronically and auto-faxed or manually faxed to a pharmacy
- Prescriptions are created electronically, printed, and handed to the patient to have filled
- 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): _______________________

PAGE 28: E-Prescribing

1. **Which statement best describes how your patients receive a prescription (other than a narcotic)?**

- Prescriptions are sent electronically from our system directly to a pharmacy without an interim step from the clinic staff or patient
- Prescriptions are created electronically and auto-faxed or manually faxed to a pharmacy
- Prescriptions are created electronically, printed, and handed to the patient to have filled
- 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): _______________________

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

**DEFINITION:** E-Prescribing sends prescriptions directly from a provider’s system to a pharmacy without an interim step from the clinic staff or patient.

- Yes, 80-100% of prescriptions are e-Prescribed
- Yes, 50-79% of prescriptions are e-Prescribed
- Yes, 25-49% of prescriptions are e-Prescribed
- Yes, less than 25% of prescriptions are e-Prescribed
- No, we do not use e-Prescribing
- Not sure

3. **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

4. **Does your clinic have and maintain an active medication list for patients (including over-the-counter medications)?**

- Yes, for 80-100% of patients
- Yes, for 50-79% of patients
- Yes, for 25-49% of patients
- Yes, for less than 25% of patients
- No, we do not have this function or it is turned off
- Not sure
5. Does your clinic maintain an active medication allergy list for patients?
   - Yes, for 80-100% of patients
   - Yes, for 50-79% of patients
   - Yes, for 25-49% of patients
   - Yes, for less than 25% of patients
   - No, we do not have this function or it is turned off
   - Not sure

6. 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
   - Not sure

7. Does your clinic perform medication reconciliation at every relevant patient encounter or transition of care?

   DEFINITION: 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 80-100% of encounters
   - Yes, for 50-79% of encounters
   - Yes, for 25-49% of encounters
   - Yes, for less than 25% of encounters
   - No, we do not have this function or it is turned off
   - Not sure

PAGE 29: 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 telemedicine services?

**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.

- Yes
- No
- Not sure

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

**DEFINITION:** E-prescribing sends prescriptions directly from a provider’s system to a pharmacy without an interim step from the clinic staff or patient.

- Yes
- No
- Not sure

5. 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>Vendor availability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Return-on-investment concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-physician provider support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration support</td>
<td></td>
<td></td>
<td></td>
</tr>
<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>
<tr>
<td>Internal knowledge/technical resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- A person to lead the implementation of the EHR
- People to help design, customize, and/or maintain an EHR for use in our clinic
- People 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: _________________________________________________________
PAGE 30: On-line Services

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

<table>
<thead>
<tr>
<th align="left">On-line appointment scheduling (patients use the Internet to contact the clinic for an appointment)</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 align="left"></td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

   | On-line bill payment                                                                                                   | ○                                                 | ○                                                   | ○       |

   | E-visits (scheduled time for provider-patient interaction via electronic medium such as e-mail or Internet)       | ○                                                 | ○                                                   | ○       |

   | Secure e-mail for communication between providers and patients                                                      | ○                                                 | ○                                                   | ○       |

   | Electronic visit reminders                                                                                           | ○                                                 | ○                                                   | ○       |

   | Blogs or on-line support groups                                                                                     | ○                                                 | ○                                                   | ○       |

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

   ○ Yes
   ○ No
   ○ Not sure

PAGE 31: Thank You!

You have completed the HIT Ambulatory Clinic Survey!

VALIDATION

MN Community Measurement will contact clinics who are selected for validation starting March 16, 2011.

If you have further questions about the HIT Ambulatory Clinic Survey, please contact Brenda Paul at paul@mncm.org.