

# 2018 Minnesota Health IT Clinic Survey

FINAL – SEPTEMBER 2018

Inquiries about this survey can be directed to:

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## Introduction

Welcome to the 2018 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 and hospitals 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 September 17, 2018 and October 17, 2018.

Survey results are used by MDH, MN e-Health Initiative, MN Community Measurement and others to:

- Measure Minnesota's status on adoption and use of technology and health information exchange;
- Identify gaps and barriers faced by clinics and their staff;
- Help develop programs and resources locally, statewide, and nationally; and
- Support community collaborative efforts.

Results will be used for public reporting by MDH and MN Community Measurement on [mnhealthscores.org](http://mnhealthscores.org).

This survey is sent to all medical group primary contacts 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. We have found the most accurate reporting of total EHR capabilities occurs when informatics staff are consulted.

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

# Clinic Information

If you need your MN Community Measurement Clinic ID, log on to <https://data.mncm.org/login> and click on "CLINIC SITES."

**1. Clinic Site**

Clinic site name \_\_\_\_\_  
MNCM Clinic ID \_\_\_\_\_  
MNCM Medical Group ID \_\_\_\_\_

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

Survey responder/survey contact  
Who is completing this survey?  
Your name: \_\_\_\_\_  
Your title: \_\_\_\_\_  
Your e-mail: \_\_\_\_\_  
Your phone number: \_\_\_\_\_

**3. What is the approximate number of patients (not visits or encounters) your clinic served during the 12 months ending July 31, 2018? Please break down by the following age groups, if possible (otherwise use a total number).**

Age 0-17 \_\_\_\_\_  
Age 18-64 \_\_\_\_\_  
Age 65+ \_\_\_\_\_  
Total, All Ages \_\_\_\_\_  
O do not know

**4. Please indicate if the percent entered above applies to:**

- Your whole medical group/system
- Only the clinic(s) listed for this survey entry

## EHR Implementation

### 5. Which statement best describes your clinic's electronic health record (EHR) system?

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

<http://www.health.state.mn.us/e-health/glossary/e.html>

- We do not have an EHR (SKIP TO Q36, NON-ADOPTERS)
- We have purchased/begun installation of an EHR but are not yet using the system
- We have an EHR installed and in use for some of our clinic staff and providers
- We have an EHR installed and in all (more than 90%) areas of our clinic

### 6. Does your clinic currently use an ONC certified EHR system?

DEFINITION: A certified EHR meets the adopted standards and certification criteria to help providers and hospitals achieve meaningful use objectives and other measures established by the Centers for Medicare and Medicaid Services (CMS). Source: <https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/certification.html>

- Yes, 2015 ONC Edition Certification
- Yes, 2014 ONC Edition Certification
- Yes, not sure which edition
- We do not use an ONC-certified EHR
- Not sure

### 7. Please select your clinic's current EHR system vendor from the drop-down list below:

(SELECT FROM DROP DOWN BOX)

Allmeds	GE Centricity	Modernizing Medicine
Allscripts	Greenway	NextGen
Athena	Healthland	Procentive
Cerner	IBM (Merge/Fusion)	Qualifacts - Carelogic
Compulink	IknowMed	SRSsoft, Inc
CPSI Medical Practice	Integrity EMR	UroChart
Credible	McKesson	
eClinicalworks	MDIntelleSys	
Epic	Meditech	

If not listed, what is your system? (Open response)

## EHR Utilization

8. Please indicate how often the following electronic clinical decision support tools are used by your clinic's providers and staff to support patient care, either through the EHR or its associated practice management system? (Respond for each tool listed)

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

	Used routinely	Used occasionally	Do not use	Not applicable
a. Automated reminders for missing or overdue labs and tests	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Chronic disease care plans and flow sheets	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Clinical guidelines based on patient problem list, gender, and age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Medication guides/alerts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Patient-specific or condition-specific reminders (e.g., foot exams for diabetic patients)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Preventive care services reminders (e.g., immunizations, screenings)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. For which conditions does your clinic use clinical decision support tools? Select all that apply.

- Diabetes
- Prediabetes
- High blood pressure
- High cholesterol
- Chronic kidney disease
- None of the above
- Not applicable

10. What other types of decision support tools does your clinic use (or would like to use) to support patient care?

(open response)

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

Definition: An advance directive is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions. From <http://www.patientsrightscouncil.org/site/advance-directives-definitions/>

- Yes
- No (SKIP TO Q14)
- Not sure (SKIP TO Q14)

**12. 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

**13. How do you store advance directive information?**

- Incorporated into our EHR, but not kept in a consistent and separate place - more likely to be stored in a progress note or with other documents
- Electronically accessible - stored in readily accessible/consistent part of the EHR
- Paper documents
- Not sure

**14. For what percentage of patients does your clinic capture demographic information in the EHR or its associated practice management system?**

	Percentage of patients				Not collected or not able to collect
	80-100%	50-79%	25-49%	Less than 25%	
a. Race	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Ethnicity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Country of origin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Preferred language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Insurance type	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Sexual orientation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Gender identity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**15. Does your EHR and/or its associated practice management system have the ability to capture and report more than one race per patient?**

- Yes
- No
- Not sure

**16. Does your EHR or its associated practice management system have the ability to capture and report granular (detailed) ethnicity information?**

Definition: Granular Ethnicity is defined as a person’s ethnic origin or descent, “roots” or heritage, or the place of birth of the person’s parents or ancestors. An example of granular ethnicity would include “Hmong”, “Vietnamese”, or “Chinese” that would map/aggregate to the category of “Asian”.

- Yes
- No (SKIP TO Q18)
- Not sure (SKIP TO Q18)

**17. For approximately what percent of patients are you capturing detailed ethnicity information?**

- 80-100% of patients
- 50-79% of patients
- 25-49% of patients
- less than 25% of patients
- Not sure

**18. Is your clinic able to generate at least one report from the data in your EHR that lists patients by a specific condition (e.g., for disease management, care coordination, research, etc.)?**

- Yes
- No (SKIP TO Q21)
- Not sure (SKIP TO Q21)

**19. For which of the following chronic conditions does your clinic regularly (at least 4 times per year) generate patient lists? Select all that apply.**

- Diabetes
- Prediabetes
- High blood pressure
- High cholesterol
- None of the above

**20. Indicate which of the following activities your clinic conducts using data from the EHR. Select all that apply.**

- Create benchmarks and/or goals for clinical priorities
- Monitor changes in patient outcomes
- Provide reports to providers (e.g., clinical dashboards)
- Track clinical outcomes
- Support care coordination
- Conduct business analytics (e.g., workflow improvement, caseload analysis, care utilization)
- Support professional development activities (e.g., certifications)
- Other (please specify): \_\_\_\_\_

**21. Does your clinic or health system use demographic information (e.g., race, age, gender) to assess disparities in clinical outcomes based on those patient characteristics?**

- Yes
- No
- Not sure

**22. What types of data would you like to have available from your EHR to support care delivery and patient outcomes (e.g., environmental exposures, housing stability, access to healthy foods, and other social determinants of health)?**

(open response)

**23. Please indicate the extent to which you agree that your EHR system has helped providers in your clinic...**

	Agree	Agree somewhat	Disagree somewhat	Disagree	Not sure or not applicable
a. Enhance patient care in your clinic	<input type="radio"/>				
b. Order fewer tests or images due to better availability of existing results	<input type="radio"/>				
c. Coordinate care with your patients' other health care providers	<input type="radio"/>				

## Privacy/Patient Consent

**24. Does your clinic's EHR allow patients to define permissions for who should have access to their health record and under what circumstances?**

- Yes
- No
- Not sure

**25. 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): \_\_\_\_\_

## Health Information Exchange

**26. When a patient was seen by a provider outside of your organization or health system, to what extent do providers at your clinic have the necessary clinical information electronically available from those outside providers (not including electronic fax or non-secure email)?**

- Routinely
- Sometimes
- Rarely or never
- Do not know

**27. When your clinic's patients need to see a provider outside of your organization or health system, to what extent your clinic routinely send the necessary clinical information electronically from your clinic's EHR (not including electronic fax or non-secure email)?**

- Routinely
- Sometimes
- Rarely or never
- Do not know

**28. Do you make referrals to health education programs (e.g., Diabetes Self-Management Program, Chronic Disease Self-Management Program, Diabetes Prevention Program) outside of your organization?**

- Yes
- No (SKIP TO Q32)
- Not sure (SKIP TO Q32)

**29. To what extent are those referrals sent electronically from your clinic's EHR (not including electronic fax or non-secure email)?**

- Routinely
- Sometimes
- Rarely or never
- Do not know

**30. To what extent are referrals confirmed electronically from your clinic's EHR (not including electronic fax or non-secure email)?**

- Routinely
- Sometimes
- Rarely or never
- Do not know

**31. To what extent is information from those referrals reported back to your clinic (i.e., "closed loop") electronically to your clinic's EHR (not including electronic fax or non-secure email)?**

- Routinely
- Sometimes
- Rarely or never
- Do not know

**32. Please describe the barriers your clinic faces to ensure providers have needed patient information to support patient outcomes. This can include types of information (e.g., labs, images, notes), ability to exchange electronically, and other barriers.**

(open response)

**33. 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)?**

A summary of care record provides essential clinical information for the receiving care team and helps organize final clinical and administrative activities for the transferring care team.

- 80-100% of patients who require referral or transition
- 50-79% of patients who referral or transition
- 25-49% of patients who referral or transition
- Less than 25% of patients who referral or transition
- Not sure
- We do not have this functionality

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

	Usually data are manually entered into the EHR	Usually data are automatically integrated into the EHR	Not sure	Not applicable
a. summary of care record	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. lab results	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. medication history	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. immunizations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. radiology or specialty consult reports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**35. Do providers at your clinic receive automatic electronic notifications (i.e., an alert) when any of their patients are admitted or discharged from the hospital, or visit the emergency department? Select all that apply.**

- Yes, from hospitals within our health system
- Yes, from hospitals outside of our health system
- No
- Not sure

## Non-Adopters

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

- Yes
- No
- Do not know

**ALL RESPONDENTS COMPLETE REST OF SURVEY**

**37. Which of the following e-health resources or workforce skills would help your clinic to advance use of HIT and/or electronic exchange of health information (HIE)? (select all that apply)**

- Implementing an EHR system, managing EHR system updates, and/or transitioning to a new EHR system
- Translating clinical needs to IT staff to optimize and/or customize EHR
- Training staff and clinics to use the EHR system
- Managing workflow changes
- Developing policies and procedures for managing data quality
- Using data analytics and/or informatics
- Managing patient consent to share health information
- Mitigating security risks to help prevent data breaches
- Developing infrastructure to support HIE
- Selecting an HIE vendor and/or negotiating an agreement
- Establishing HIE agreements with exchange partners (e.g., Business Associate Agreement)
- Integrating patient data from external sources into our EHR
- Understanding and/or using nationally recognized e-health standards
- Understanding Federal and State laws relating to e-health, health information exchange, and consent
- Technical assistance to support HIE with MDH
- Other (please specify)

## Patient Electronic Access

**38. Does your clinic offer an online patient portal?**

DEFINITION: A patient portal is an internet application that allows patients to access their electronic health records and permits two-way communication between patients and their healthcare providers. (Source HealthIT.gov: <https://www.healthit.gov/faq/what-patient-portal>)

- Yes, we have a patient portal
- No, we don't have a patient portal (SKIP TO Q42)
- Not sure (SKIP TO Q42)

**39. Which of the following features or functionalities are available to the patients through the patient portal? (select all the apply)**

- Access to care plans
- Access to all or some of providers' progress notes/documentation (e.g., OpenNotes)
- Immunization records
- E-Visits
- Patient education materials
- Submission of home-based health data (e.g., blood sugar, blood pressure values)

**40. Approximately what percent of your clinic's active patients have signed up for the patient portal?**

\_\_\_\_%

**41. Indicate which functions your clinic offers to patients to access and use their patient health information (select all that apply):**

- View online (patient or authorized representative can access their health information online)
- Download (patient or authorized representative can download their health information to a physical electronic media (USB, CD) or into a PDF document)
- Transmission (patient or authorized representative can transmit their health information through any means of electronic transmission according to transport standards; this does not include downloading information to physical electronic media)
- None of the above
- Not sure

## Telemedicine

**42. Does your clinic use telemedicine services? This does not include telemonitoring.**

DEFINITION: Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patients' health status. (Definition attributed to the American Telemedicine Association, <http://www.americantelemed.org/about/telehealth-faqs->)

- Yes
- No (SKIP TO Q44)
- Do not know (SKIP TO Q44)

**43. For which of the following activities does your clinic use telemedicine? (select all that apply)**

- Primary care consultation with clinical specialists (e.g., cardiology, radiology, dermatology, neurology, etc.)
- Specialty care consultation with primary care clinician
- Hospital/emergency department consultation with your clinic
- Urgent care
- Consultation with long-term and post-acute care, including hospice care
- Chronic disease management (e.g., diabetes self-management education)
- Psychiatry or psychology
- Wound care
- Rehabilitation therapies
- Lifestyle change education (e.g. Diabetes Prevention Program, Weight Watchers, etc.)
- Other (please specify) \_\_\_\_\_

## E-Prescribing

### 44. Approximately what percent of your clinic's prescriptions are electronically prescribed?

- a. For prescriptions that DO NOT include controlled substances \_\_\_\_\_%
- b. For prescriptions that INCLUDE controlled substances \_\_\_\_\_%

### 45. Does your clinic utilize the electronic Formulary and Benefit Standard for reviewing medication formulary and benefit information?

Definition: The Formulary and Benefit Standard are files from the payer that prescribers use to identify formulary status (i.e. preferred/non-preferred), copay and coverage information (i.e. PA, age/quantity limits) and alternative product information.

- Yes
- No (SKIP TO Q48)
- Not sure (SKIP TO Q48)

### 46. How helpful is the information in e-prescribing decisions?

- Very helpful
- Somewhat helpful
- Not helpful
- Not sure

### 47. Describe how this information could be more helpful for your practice.

(open response)

### 48. To what extent do prescribers in your clinic use electronic prior authorization (ePA) to request medication prior authorizations requests with payers and pharmacy benefit managers?

Definition: Prior Authorization (PA) is the process that is used to request coverage of a specific medication for a specific patient. Electronic Prior Authorization (ePA) is the electronic transmission of information between the prescriber and payer/PBM to determine whether or not the PA is granted. (Source:

[https://www.ncdpd.org/NCPDP/media/pdf/NCPDP\\_ePA\\_Fact\\_Sheet.doc](https://www.ncdpd.org/NCPDP/media/pdf/NCPDP_ePA_Fact_Sheet.doc))

- For 80-100% of prescriptions
- For 50-79% of prescriptions
- For 25-49% of prescriptions
- For less than 25% of prescriptions
- We do not use electronic prior authorizations
- Not sure

# Administrative Transactions

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

**49. Does your clinic routinely check insurance eligibility electronically using the standard known as the “270/271”?**

- Yes, for 50-100% of patients
- Yes, for less than 50% of patients
- No
- Not sure

**50. Does your clinic receive electronic remittance advices (ERA) using the standard known as the “835” ?**

- Yes, for 50-100% of claims
- Yes, for less than 50% of claims
- No
- Not sure

**51. Does your clinic receive electronic acknowledgements of their claims submissions using any of the standards known as the “TA1,” “999,” or “277CA”?**

- Yes, for 50-100% of claims
- Yes, for less than 50% of claims
- No
- Not sure

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