



Rhode Island Health Care Quality Performance (HCQP) Program

PHYSICIAN HIT SURVEY

This survey asks about physicians' use of health information technology (HIT) and should take less than 10 minutes to complete. The questions are intended for licensed physicians in active practice.

Instructions: Please answer the following questions based on your current practice.

SECTION A: Physician and Practice Information

1. What is your name? Last name First name Middle Initial Degree(s)

2. Are you licensed in Rhode Island?

No, and I am not licensed in any other state(s) - skip to Question 24 on page 6

No, but I am licensed in another state(s)

Yes, and my Rhode Island license information is:

a. Rhode Island medical license number: \_\_\_\_\_

b. License type: (choose one)

MD DO Other: (please specify) \_\_\_\_\_

3. Aside from Rhode Island, are you licensed in any other state(s)? (circle all that apply)

- AL CT ID LA MS NJ OK TX WI
AK DE IL ME MO NM OR UT WY
AZ DC IN MD MT NY PA VT
AR FL IA MA NE NC SC VA
CA GA KS MI NV ND SD WA
CO HI KY MN NH OH TN WV

4. Are you currently in active clinical practice (i.e., providing direct patient care services)?

No - Skip to Question 24 on page 6

Yes, and my primary specialty is: (select one)

- Anesthesia OB/GYN Radiation Therapy/Oncology
Ear, Nose, and Throat Occupational Therapy Radiology
Emergency Medicine Orthopaedic Surgery Rheumatology
Family Medicine Pathology Thoracic Surgery
General Surgery Pediatrics Urology
Internal Medicine Psychiatry Other: (please specify)
Neurology Primary Care

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## 5. How many hours per week do you spend in direct patient care?

<sub>1</sub> <10 hours    <sub>2</sub> 10-20 hours    <sub>3</sub> >20 hours

6. Do you plan to retire within the next five (5) years? (*This information is confidential.*)

<sub>1</sub> No

<sub>2</sub> Yes

7. What is your **main** practice's name and mailing address? By 'main practice,' we mean the practice where you spend the majority of the time you provide direct patient care.

Practice name

Practice Address

Box/Suite

City/Town

State

ZIP Code

8. How many colleagues are in your **main** practice?

	Part-Time	Full-Time
Physicians:	_____	_____
Nurse practitioners:	_____	_____
Physician assistants:	_____	_____

**SECTION B: Electronic Medical Records (EMR) Use\***9. Does your **main** practice have EMR components? By 'EMR components,' we mean an integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc. (check all that apply)

<sub>1</sub> No → a. When does your **main** practice plan to implement an EMR?

<sub>1</sub> <1 year

<sub>2</sub> 1-2 years

<sub>3</sub> 3+ years

<sub>4</sub> Don't know or no specific plans

b. Does another practice in which you provide direct patient care have EMR components?

<sub>1</sub> No

<sub>2</sub> Yes → Please answer the remaining questions based on a single practice with EMR components.

<sub>2</sub> Yes

\* EMR questions adapted with permission from: (1) Simon et al. Physicians and electronic health records: A statewide survey. *Arch Intern Med* 2007; 167: 507-512; and (2) Simon et al. Correlates of electronic health record adoption in office practices: A statewide survey. *J Am Med Inform Assoc* 2007; 14: 110-117.

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## 10. Please indicate the extent to which you consider each of the following to be a barrier to EMR implementation:

	Not a barrier	Minor barrier	Major barrier
Access to technical support	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Computer skills	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Lack of uniform industry standards	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Ongoing financial costs	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Privacy or security concerns	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Start-up financial costs	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Technical limitations of systems	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Training and productivity loss	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Other (please specify): _____			

➔ The following questions are for all physicians using EMRs, regardless of specialty. If you don't have an EMR in either your main practice or another practice, skip to Question 21 on page 5.

## 11. Please provide the following information about the EMR you use. If your main practice has an EMR, answer these questions based on your main practice. If your main practice does not have an EMR, answer them based on the practice with an EMR in which you spend the most time providing direct patient care.

## a. What is your EMR vendor?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> <sub>1</sub> Allscripts          | <input type="checkbox"/> <sub>8</sub> GE Centricity            | <input type="checkbox"/> <sub>15</sub> Practice Partner              |
| <input type="checkbox"/> <sub>2</sub> Amazing Charts      | <input type="checkbox"/> <sub>9</sub> Greenway                 | <input type="checkbox"/> <sub>16</sub> Sage - Intergy EHR            |
| <input type="checkbox"/> <sub>3</sub> Athena Health       | <input type="checkbox"/> <sub>10</sub> Lighthouse MD           | <input type="checkbox"/> <sub>17</sub> SOAPware                      |
| <input type="checkbox"/> <sub>4</sub> Cerner - PowerChart | <input type="checkbox"/> <sub>11</sub> McKesson Provider Tech. | <input type="checkbox"/> <sub>18</sub> Other: (please specify) _____ |
| <input type="checkbox"/> <sub>5</sub> eClinicalWorks      | <input type="checkbox"/> <sub>12</sub> Misys                   |  |
| <input type="checkbox"/> <sub>6</sub> e-MD                | <input type="checkbox"/> <sub>13</sub> Next Gen                |  |
| <input type="checkbox"/> <sub>7</sub> Epic Systems        | <input type="checkbox"/> <sub>14</sub> Polaris - EpiChart      |  |

## b. In which year did your practice install its EMR? \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

## c. Is the EMR Certification Commission on Health Information Technology (CCHIT) certified?

- <sub>1</sub> No    <sub>2</sub> Yes    <sub>3</sub> Don't Know

## 12. Did your practice receive financial or other incentives to implement an EMR?

- <sub>1</sub> No    <sub>2</sub> Yes    <sub>3</sub> Don't Know

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➔ For the following questions, please indicate the percent of patients with whom you use these EMR functionalities when the functionalities are applicable to the patient or situation. Choose 'N/A' if your EMR does not have a particular EMR functionality.

## 13. Please indicate the extent to which you use this demographic functionality:

	0%	<30%	30%-60%	>60%	N/A
Patient demographics (e.g., address, phone number, date of birth, gender)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

14. Please indicate the extent to which you use clinical documentation functionalities as patients are seen in your office:

	0%	<30%	30%-60%	>60%	N/A
Electronic visit notes	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Electronic lists of each patient's medication	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Electronic problem lists	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Patient clinical summaries for referral purposes	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

15. Please indicate the extent to which you use clinical documentation functionalities when you are not in the office and need access to clinical information:

	0%	<30%	30%-60%	>60%	N/A
Remote access to medication lists	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Remote access to problem lists	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

## 16. Please indicate the extent to which you use this interoperability functionality:

	0%	<30%	30%-60%	>60%	N/A
Electronic referrals or clinical messaging (secure emailing with providers outside your office)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

## 17. Please indicate the extent to which you use these order management functionalities:

	0%	<30%	30%-60%	>60%	N/A
Laboratory order entry	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Medication order entry	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Radiology order entry	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

## 18. Please indicate the extent to which you use these reporting functionalities:

	0%	<30%	30%-60%	>60%	N/A
Clinical quality measures (e.g., the percent of diabetics with a glycohemoglobin test)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

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	0%	<30%	30%-60%	>60%	N/A
Patients out of compliance with clinical guidelines (e.g., a list of women over age 50 without a recent mammogram)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Patients with a condition (e.g., diabetes), characteristic (e.g., men over age 60) or risk factor (e.g., obesity)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

## 19. Please indicate the extent to which you use these results management functionalities:

	0%	<30%	30%-60%	>60%	N/A
Laboratory test results directly from lab via electronic interface	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Scanned paper laboratory test reports	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Radiology test results directly from facility via electronic interface	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Scanned paper radiology test reports	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

## 20. Please indicate the extent to which you use these other functionalities:

	0%	<30%	30%-60%	>60%	N/A
Drug interaction warnings at the point of prescribing	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Letters or other reminders directed at patients regarding indicated or overdue care	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
Prompts at the point of care, regarding indicated care specific to the patient's condition(s)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

## SECTION C: Electronic Prescribing (e-Prescribing) Use

## 21. What percent of the time do you transmit prescriptions electronically to the pharmacy? (exclude faxing)

- <sub>1</sub> 0% → skip to Question 23, below
- <sub>2</sub> <30%
- <sub>3</sub> 30%-60%
- <sub>4</sub> >60%

## 22. Do you transmit these prescriptions using an EMR?

- <sub>1</sub> No
- <sub>2</sub> Yes → skip to Question 24 on page 6

## 23. Do you plan to transmit prescriptions using an EMR within the next 12 months?

- <sub>1</sub> No
- <sub>2</sub> Yes

**ELECTRONIC MEDICAL RECORDS QUESTIONNAIRE**

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24. **Please use this space to provide additional comments:** \_\_\_\_\_

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*Thank you for taking the time to complete this survey.*

*Please visit the Rhode Island Department of Health's Health Care Quality Performance (HCQP) Program Web site to learn more about the state's public reporting efforts: <http://www.health.ri.gov/chic/performance>*