

APPENDIX B
**A National Survey of Health Record Keeping among Physicians &
Group Practices in the United States.**

This survey asks about medical record keeping. Please return the survey with your answers in the enclosed postage-paid envelope.

- Answer the questions by putting an “X” in the appropriate answer box like this:

Have you taken a vacation in the past year?

yes

no

- Some questions ask you to report a number, such as the number of patients you see in a given week. Please write your best estimate of the number in the space provided. For numbers less than 1, please use fractions, or percentages as appropriate.

Notice of respondent confidentiality.

All information that would permit identification of any person who is chosen for this survey **will be kept under the strictest protections allowed by law.** This information will be used only for the purposes of this study and will not be disclosed or released for any other purposes without your permission. None of the questions ask about the care you provide to individual patients. If you have questions concerning your rights as a research subject, please call the Office for Research Protection at RTI-International toll-free at 866-214-2043.

If you have any questions or want to know more about the study or to find out about reports that are generated from this data collection effort, please call RTI’s project director, Dr. John D. Loft, toll free at 800-EHR-0000.

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to HHS/OS Reports Clearance Officer, 200 Independence Ave. SW, Washington DC 20201; ATTN: PRA (0990-XXXX).

PHYSICIAN SURVEY

000. Practice Characteristics

001. At how many different office locations do you see ambulatory patients?
- ₁ One
 - ₂ Two
 - ₃ Three or more
 - ₄ None, I do not see any outpatients

*If you practice at more than one location, please keep in mind your **main practice site** for the remaining questions. By “main practice site” we mean the location at which you see the most ambulatory patients.*

002. During a typical week, what percent of your patient visits are provided at your *main practice site*?
- ₁ Less than 25%
 - ₂ 25%-49%
 - ₃ 50% - 75%
 - ₄ More than 75%

003. How many physicians are associated with you, at your main practice site? _____.

004. Is your main practice site a single-specialty practice, or a multi-specialty practice?

- ₁ Single specialty group or partnership
- ₂ Multi-specialty group or partnership

005. What is the primary setting of your main practice site?

- ₁ Hospital, medical-center.
- ₂ Ambulatory surgical center.
- ₃ Urgent-care facility.
- ₄ Laboratory or imaging center, outside a hospital.
- ₅ An physician office not attached to a hospital, or on a medical center campus.

006. About what percentage of your patients in your main practice site:

	Less than 10%	10% to less than 25%	25% to less than 50%	50% or more
a. are uninsured (do <u>not</u> have health insurance coverage)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b. are covered by <u>Medicaid</u> (including managed care)?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c. are African American or Black?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e. are Hispanic or Latino?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
f. have a primary language <u>other than English</u> ?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

007. During your last full week of work, approximately how many patient visits did you personally have at your main practice site?

_____.

100. Use of computers in your main practice site

101. Does your main practice site have a computerized system for any of the following? For those features

that you have, indicate the extent to which **you** use them:

	Availability			Use			
	Yes	No	Don't Know	I do not use	I use <i>some</i> of the time	I use <i>most or all</i> of the time	Not applicable to my practice or specialty
a) Patient demographics	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) Patient problem lists	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) Orders for prescriptions?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d) <i>If yes</i> – are there warnings of drug interactions or contraindications provided	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e) <i>If yes</i> - Are prescriptions set electronically to the pharmacy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
f) Orders for laboratory tests?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
g) <i>If yes</i> – are orders sent electronically?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
h) Orders for radiology tests?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
i) <i>If yes</i> , Are orders sent electronically?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
j) Viewing Lab results?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
k) <i>If yes</i> – are out of range levels highlighted?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
l) Viewing Imaging results	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
m) <i>If yes</i> – are electronic images returned?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
n) Clinical notes?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
o) <i>If yes</i> – do they include medical history and follow up notes?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
p) Electronic lists of what medications each patient takes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
q) Reminders for guideline-based interventions and/or screening tests?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
r) Public health reporting?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
s) <i>If yes</i> : Are notifiable diseases sent electronically?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

200. Acquisition and Implementation of an EHR system

201. Does your *main* practice use an electronic health record (not including billing records)?

- ₁ Yes, all electronic
- ₂ Yes, part paper, part electronic
- ₃ No
- ₄ Don't know

202. As of today, what is your degree of electronic health record acquisition or implementation at your main practice site [Choose one]

- ₁ We have no plans to acquire an EHR system (go to next page)
- ₂ Our EHR implementation is in process (go to next page)
- ₃ We have fully implemented our EHR system (go to next page)
- ₄ We plan to acquire an EHR system in the next 12 months (go to next page)
- ₅ We plan to acquire an EHR system in the next 13 – 24 months (go to next page)
- ₆ We have acquired an EHR system, but have not implemented it (**go to Question 203**)

203. If you have purchased and are in the process of implementing an EHR system, when do you expect to have completed implementation?

- ₁ in the next 12 months.
- ₂ in the next 13 to 24 months.

IF YOUR MAIN PRACTICE SITE USES PAPER RECORDS PLEASE GO TO SECTION 400. IF YOUR SITE USES ELECTRONIC HEALTH RECORDS OR IS IN TRANSITION TO AN EHR SYSTEM PLEASE COMPLETE THE FOLLOWING SECTION.

300. Experience with Electronic Health Records

301. How many years have you been using an EHR in your main practice site? _____.

302. To what extent has the EHR system affected the following areas at your main practice site?

	Major positive impact	Positive impact	No impact	Negative impact	Major negative impact	Not applicable
a) The quality of clinical decisions	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
b) Communication with other providers	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
c) Communication with your patients	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
d) Prescription refills	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
e) Timely access to medical records	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
g) Avoiding medication errors	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
f) Delivery of preventive care that meets guidelines	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
g) Delivery of chronic illness care that meets guidelines	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

303. In providing patient care since adopting an EHR system at your main practice site, have you

	Yes		No	Not applicable
	In the last 6 months	Ever		
a) Avoided a drug allergy because of an EHR?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) Avoided a potentially dangerous medication interaction because of an EHR?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) Been alerted to a critical lab value by an EHR?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d) Provided preventive care (e.g., vaccine, colonoscopy, mammogram) because you were prompted by an EHR?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e) Ordered a critical lab test (such as HbA1c or LDL) as a result of an electronic prompt from an EHR?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

304. Overall, how satisfied are you with the EHR system at your main practice?

Very satisfied ₁
 Somewhat satisfied ₂
 Somewhat dissatisfied ₃
 Very dissatisfied ₄

305. How satisfied are you with each of the following aspects of your EHR system

Very satisfied
 Somewhat satisfied
 Somewhat dissatisfied
 Very dissatisfied

a) Ease of use when providing direct care to a patient	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) Reliability of the system (i.e. frequency of system failures, system speed)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) Sharing of medical information with hospitals and other health-care providers?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

306. Please indicate whether the EHR system at your *main practice site* allows patients to...

	Yes	No	Don't know
a. View their medical record online	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b. Make changes to or update their medical record online	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
c. Request appointments online	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d. Request referrals online	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e. Request refills for prescriptions online	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

307. Is electronic health record system at your main practice site integrated with a hospital system where you admit patients (i.e. your patient's ambulatory EHR is accessible through the hospital's EHR system)?

Yes	No	Don't know
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

400. Use of Email

401. Please indicate how frequently you communicate by email with each of the following

	Never	Rarely	Sometimes	Frequently
a) patients about medical issues	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b) other physicians in your practice about patient care	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c) other staff in your practice about patient care	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d) other physicians who are not in your practice about patient issues	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

500. Barriers to EHR adoption

501. Please answer the next set of questions, regardless of whether your main practice site has acquired an EHR system or has not. If your practice site has acquired an EHR system, please tell us how much of a barrier each of the following was. If your practice has not acquired an EHR, please indicate how much of a barrier it is to adoption, even if you have no immediate plans to adopt.

	Major barrier	Minor barrier	Not a barrier
Financial Barriers			
a. The amount of capital needed to acquire and implement an HER	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
b. Uncertainty about the return on investment (ROI) from an HER	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Organizational Barriers			
c. Resistance to adoption from practice physicians	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
d. Capacity to select, contract, install and implement an EHR	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
e. Concern about loss of productivity during transition to the EHR system	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Legal or Regulatory Barriers			
f. Concerns about inappropriate disclosure of patient information (i.e. breaches of patient confidentiality?)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
g. Concerns about illegal record tampering or “hacking”	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
h. Concerns about the legality of accepting an EHR that is donated from a hospital	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
i. Concerns about physicians’ legal liability if patients have more access to information in their medical records	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
State of the Technology			
j. Finding an EHR system that meets providers’ needs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
k. Concerns that the system will become obsolete	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

600. Incentives for EHR adoption

601. Please rate the impact the following possible policy changes would have on your decision to adopt an EHR. If you have adopted an EHR, please rate the impact of the following possible policy changes on EHR adoption among physicians generally. Please indicate whether the impact was positive or negative.

	Major positive impact	Minor positive impact	No Impact	Minor negative impact	Major negative impact
Legal or Regulatory Barriers					
a. Change the law to protect physicians from personal liability for record tampering by external parties or for privacy and security breaches	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
b. Concerns about legal liability as a result of NOT using the latest technology	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
State of the Technology					
c. Published certification standards that indicate whether an EHR has the necessary capabilities and functions.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Financial Barriers					
d. Incentives for the purchase of an EHR (e.g. tax credits, low interest loans, grants)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
e. Additional payment for the use of an EHR (i.e. additional reimbursement for using an EHR).	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

602. Has your practice undertaken any of these capital investments *in the last three years?*

	Yes	No	Don't know
Added new examining rooms.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Purchased an x-ray or imaging machine.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Acquired or opened another practice site	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Purchased clinical laboratory equipment	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

900. Physician and practice characteristics

901. What is the year of your birth? 19_____

902. What is your gender?

₁ Male ₂ Female

903. What is your ethnicity?

₁ Hispanic or Latino

₂ Not Hispanic or Latino

904. What is your race? (check all that apply)

₁ White

₂ Black/African American

₃ Asian

₄ Native Hawaiian/Other Pacific Islander

₅ American Indian/Alaska Native

905. What is your primary specialty? _____

906. What is your secondary specialty? _____

907. In what year did you first practice medicine, after completing residency or fellowship? _____

Roughly, what percent of your patient care revenue comes from (note percentage to total to 100).

_____ Medicare

_____ Medicaid

_____ Private insurance

_____ Patient payments

_____ Other _____.

IF YOU ARE KNOWLEDGABLE ABOUT DECISIONS REGARDING EHR ADOPTION IN YOUR PRACTICE, PLEASE COMPLETE THE SECOND HALF OF THIS FORM. IF NOT, PLEASE ASK THE MOST KNOWLEDGABLE PERSON AT YOUR MAIN PRACTICE SITE TO COMPLETE THE SECOND HALF OF THIS FORM AND TO RETURN IT IN THE POSTAGE-PAID ENVELOPE PROVIDED.

THANK YOU FOR COMPLETING THIS FORM. PLEASE RETURN IT IN THE ENCLOSED ENVELOPE.