

# **ATTACHMENT T**

**NAMCS EMR Supplement 2010**

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# National Ambulatory Medical Care Survey (NAMCS):

## Electronic Medical Records Supplement 2010

The purpose of the National Study of Electronic Medical Records/Electronic Health Records (EMR/EHR) is to collect information about physician office practices and the adoption of electronic medical records in ambulatory care settings. Your participation is greatly appreciated. Your answers are completely confidential. Participation in this survey is voluntary. If you have questions or comments about this survey, please call 866-635-4515.

### 1. We have your specialty as

Is that correct?

1 Yes

2 No → What is your specialty? \_\_\_\_\_

*The following questions ask about **ambulatory patients**. We define ambulatory patients as any patients coming to see you for personal health services who are not currently on the premises.*

### 2. Do you directly care for any ambulatory patients in your work?

1 Yes → Continue to Question 3.

2 No

3 I am no longer in practice

} Please stop here and return the questionnaire in the envelope provided. Thank you for your time.

### 3. In a typical year, about how many weeks do you NOT see any ambulatory patients because of such events as conferences, vacations, illness, etc.?

\_\_\_\_\_ weeks

*The next set of questions asks about a **normal week**. We define a normal week as a week with a normal case load, no holidays, vacations, or conferences.*

### 4. Overall, at how many office locations do you see ambulatory patients in a normal week?

\_\_\_\_\_ locations

### 5. During your last normal week of practice how many patient visits did you have at all locations?

\_\_\_\_\_ visits

### 6. During your last normal week of practice, about how many encounters of the following type did you make with patients?

1. Nursing home visits \_\_\_\_\_
2. Other home visits \_\_\_\_\_
3. Hospital visits \_\_\_\_\_
4. Telephone consults \_\_\_\_\_
5. Internet / e-mail consults \_\_\_\_\_

**7. Do you see ambulatory patients in any of the following settings? CHECK ALL THAT APPLY.**

- 1 Private solo or group practice
- 2 Freestanding clinic/urgicenter (not part of a hospital outpatient department)
- 3 Community Health Center (e.g., Federally Qualified Health Center (FQHC), federally funded clinics or "look alike" clinics)
- 4 Mental Health Center
- 5 Non-federal Government clinic (e.g., state, county, city, maternal and child health, etc.)
- 6 Family planning clinic (including Planned Parenthood)
- 7 Health maintenance organization or other prepaid practice (e.g., Kaiser Permanente)
- 8 Faculty Practice Plan

**8. Do you see ambulatory patients in any of the following settings? CHECK ALL THAT APPLY.**

- 9 Hospital emergency department
- 10 Hospital outpatient department
- 11 Ambulatory surgicenter
- 12 Institutional setting (school infirmary, nursing home, prison)
- 13 Industrial outpatient facility
- 14 Federal Government operated clinic (e.g., VA, military, etc.)
- 15 Laser vision surgery

**9. At which of the settings in question 7 do you see the most ambulatory patients? WRITE THE NUMBER LOCATED NEXT TO THE BOX YOU CHECKED.**

\_\_\_\_\_ 16 Did not check any boxes in question 7



*If you **only** see patients in a **reporting location** checked in **question 8**, please mark box 16 above, stop and return the questionnaire in the envelope provided. Thank you for your time.*

*For the remaining questions, please answer regarding the **reporting location indicated in question 9** even if it is not the location where this survey was sent.*

**10. What are the county, state, zip code and telephone number of the reporting location?**

Country \_\_\_\_\_ USA \_\_\_\_\_  
County \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Telephone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**11. During your last normal week of practice, approximately how many office visits did you have at the reporting location? (A normal week would be one with a normal case load, no holidays, vacations or conferences.)**

*Note: Please only include visits where you personally saw the patient.*

\_\_\_\_\_ office visits

**12. Is the reporting location a solo practice, or are you associated with other physicians in a partnership, in a group practice or in some other way?**

- 1 Solo → **SKIP to Question 15**
- 2 Associated with others

**13. How many physicians are associated with you at the reporting location?**

\_\_\_\_\_ physicians

**14. Is the reporting location a single- or multi-specialty (group) practice?**

- 1 Single
- 2 Multi

**15. How many mid-level providers (i.e., nurse practitioners, physician assistants, and nurse midwives) are associated with the reporting location?**

\_\_\_\_\_ mid-level providers

**16. Does the reporting location submit claims electronically (electronic billing)?**

- 1 Yes, all electronic
- 2 Yes, part paper and part electronic
- 3 No
- 4 Unknown

**17. Does the reporting location use an electronic medical record (EMR) or electronic health record (EHR) system? Do not include billing record systems.**

- 1 Yes, all electronic
  - 2 Yes, part paper and part electronic
  - 3 No
  - 4 Unknown
- } Go to Question 17a.
- } Skip to Question 18.

**17a. Which year did you install your EMR/EHR system? \_\_\_\_\_**

**17b. What is the name of your current EMR/EHR system? CHECK ONLY ONE BOX. IF OTHER IS CHECKED, PLEASE SPECIFY THE NAME.**

- 1 Allscripts
- 2 Cerner
- 3 eClinicalWorks
- 4 Eclipsys
- 5 Epic
- 6 eMDs
- 7 GE Centricity
- 8 Greenway Medical
- 9 HealthPort
- 10 McKesson
- 11 NextGen
- 12 Praxis
- 13 Practice One
- 14 Sage Intergy
- 15 Other \_\_\_\_\_
- 16 Unknown

**18. At the reporting location, are there plans for installing a new EMR/EHR system within the next 18 months?**

- 1 Yes
- 2 No
- 3 Maybe
- 4 Unknown

**19. Please indicate whether the reporting location has each of the computerized capabilities listed below. CHECK NO MORE THAN ONE BOX PER ROW. Does the reporting location have a computerized system for:**

	Yes	Yes, but turned off or not used	No	Unknown
<b>19a. Patient history &amp; demographic information?</b>	1 <input type="checkbox"/> <i>Go to 19a1</i>	2 <input type="checkbox"/> <i>Skip to 19b</i>	3 <input type="checkbox"/> <i>Skip to 19b</i>	4 <input type="checkbox"/> <i>Skip to 19b</i>
<b>19a1.</b> If yes, does this include a patient problem list?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>19b. Clinical notes?</b>	1 <input type="checkbox"/> <i>Go to 19b1</i>	2 <input type="checkbox"/> <i>Skip to 19c</i>	3 <input type="checkbox"/> <i>Skip to 19c</i>	4 <input type="checkbox"/> <i>Skip to 19c</i>
<b>19b1.</b> If yes, do they include a list of medications that the patient is taking?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>19b2.</b> If yes, does this include a comprehensive list of the patient's allergies (including allergies to medication)?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>19c. Orders for prescriptions?</b>	1 <input type="checkbox"/> <i>Go to 19d1</i>	2 <input type="checkbox"/> <i>Skip to 19e</i>	3 <input type="checkbox"/> <i>Skip to 19e</i>	4 <input type="checkbox"/> <i>Skip to 19e</i>
<b>19c1.</b> If yes, are warnings of drug interactions or contraindications provided?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>19c2.</b> If yes, are prescriptions sent electronically to the pharmacy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>19d. Orders for lab tests?</b>	1 <input type="checkbox"/> <i>Go to 19d1</i>	2 <input type="checkbox"/> <i>Skip to 19e</i>	3 <input type="checkbox"/> <i>Skip to 19e</i>	4 <input type="checkbox"/> <i>Skip to 19e</i>
<b>19d1.</b> If yes, are orders sent electronically?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

	Yes	Yes, but turned off or not used	No	Unknown
<b>19e. Viewing lab results?</b>	1 <input type="checkbox"/> <i>Go to 19e1</i>	2 <input type="checkbox"/> <i>Skip to 19f</i>	3 <input type="checkbox"/> <i>Skip to 19f</i>	4 <input type="checkbox"/> <i>Skip to 19f</i>
<b>19e1. If yes, are results incorporated into EMR/EHR?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>19e2. If yes, are out of range levels highlighted?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>19f. Viewing imaging results?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>19g. Reminders for guideline-based interventions or screening tests?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>19h. Electronic reporting to immunization registries?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

**20. At the reporting location, if orders for prescriptions or lab tests are submitted electronically, who submits them? CHECK ALL THAT APPLY.**

1 Prescribing practitioner  
2 Other clinician (including RN)  
3 Lab technician  
4 Administrative personnel  
5 Other  
6 Prescriptions and lab test orders not submitted electronically

**21. Beginning in 2011, Medicare and Medicaid will offer incentives to practices that have “meaningful use of Health IT”. At the reporting location, are there plans to apply for Medicare or Medicaid incentive payments for meaningful use of Health IT?**

1 Yes, we intend to apply → *Go to Question 21a.*  
2 Uncertain whether we will apply } *Skip to Question 22.*  
3 No, we will not apply

**21a. What year do you expect to apply for the meaningful use payments?**

1 2011  
2 2012  
3 After 2012  
4 Unknown

**21b. What incentive payment do you plan to apply for? CHECK ONE.**

1 Medicare  
2 Medicaid  
3 Unknown

**22. Are you a full- or part-owner, employee, or independent contractor of the reporting location? CHECK ONE.**

1 Owner (full or part)  
2 Employee  
3 Contractor

**23. Who owns the reporting location? CHECK ONE.**

1 Physician or physician group  
2 HMO  
3 Community health center  
4 Medical / academic health center  
5 Other hospital  
6 Other health care corporation  
7 Other

**24. At the reporting location, what percent of your patient care revenue comes from the following?**

1. Medicare \_\_\_\_\_ %  
2. Medicaid \_\_\_\_\_ %  
3. Private insurance \_\_\_\_\_ %  
4. Patient payments \_\_\_\_\_ %  
5. Other (including charity, research, CHAMPUS, VA, etc.) \_\_\_\_\_ %

**TOTAL** 100%

**25. Who completed this survey?**

1 The physician to whom it was addressed  
2 Office staff  
3 Other

**Thank you for your participation. Please return your survey in the envelope provided. If you have misplaced this envelope, please send the EMR survey to the following address: 2605 Meridian Parkway, Suite 200, Durham, NC 27713-5254**