

Selected AD Survey Screenshots:

ECONOMETRICA, INC.

Evaluation of PQRS and eRx: Administrator Survey

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September 2013
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

Survey Instructions

The following survey asks questions about your participation in the Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) Incentive Program. As you answer each question, please remember there is no right or wrong answer; we are just interested in your thoughts and opinions on this topic.

- Answer each question by clicking your cursor on the circle to the left of your answer.
- Sometimes the survey will skip over certain questions automatically based on your response.
- If you have any questions or need help completing the survey, please contact Econometrica toll-free at 1-888-207-0728 from 9:00 a.m. to 5:00 p.m. CST or send an email to PQRSeRx@econometrica.com.

Please begin the survey now.

Next

B: BACKGROUND

*B1. What is the *main* specialty of your practice?

- Cardiovascular diseases
 - Emergency medicine
 - Family practice
 - General internal medicine
 - Nephrology
 - Other (please specify)
- Oncology
 - Ophthalmology
 - Psychiatry
 - Urology

*B2. Which of the following best describes your *main* practice setting?

- Hospice
 - Hospital, teaching
 - Hospital, non-teaching
 - Laboratory
 - Multi-specialty group practice or clinic
 - Other (please specify):
- Physician's office, single specialty group practice
 - Physician's office, solo practice
 - Skilled nursing facility
 - Urgent care facility

*B3. Including yourself, if applicable, how many full-time equivalent (FTE) health practitioners are in your practice?

(Full-time equivalent health practitioners are clinicians who work 20 hours or more, per week. Each person who works more than 20 hours is counted as 1 FTE.)

Number of FTE physicians	<input type="text"/>
Number of FTE nurse practitioners	<input type="text"/>
Number of FTE physician assistants	<input type="text"/>
Number of other clinical providers (excluding clinic assistants):	<input type="text"/>

E: PQRS FEEDBACK REPORT

*E1. Have you successfully downloaded any PQRS feedback reports from CMS?

- Yes
- No

*E2. If yes, what year(s) did you successfully download the PQRS feedback report? *{Select all that apply.}*

- | | | |
|-------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> 2007 | <input type="checkbox"/> 2010 | <input type="checkbox"/> 2013 |
| <input type="checkbox"/> 2008 | <input type="checkbox"/> 2011 | |
| <input type="checkbox"/> 2009 | <input type="checkbox"/> 2012 | |

*E3. How easy was it to download the PQRS feedback report?

- | | |
|--------------------------------------|---------------------------------|
| <input type="radio"/> Very difficult | <input type="radio"/> Easy |
| <input type="radio"/> Difficult | <input type="radio"/> Very easy |

*E4. Did you share the PQRS feedback report with any health practitioners at your practice?

- Yes
- No

Selected EP Survey Screenshots:



A: SURVEY ELIGIBILITY

*A1. Are you a physician, a nurse practitioner, a physician assistant, or some other type of health care provider?

- | | |
|---|--|
| <input type="radio"/> Physician (MD/DO) | <input type="radio"/> Physician Assistant |
| <input type="radio"/> Nurse Practitioner | <input type="radio"/> Not a Health Care Provider |
| <input type="radio"/> Other (please specify):
<input type="text"/> | |

*A2. Do you accept payment from Medicare?

- Yes
- No

*A3. How many years have you been in practice since you completed your training?

- | | |
|---|---|
| <input type="radio"/> Still in residency or training (e.g., completing field work, clinical experience) | <input type="radio"/> 6 - 10 years |
| <input type="radio"/> Less than 1 year | <input type="radio"/> Greater than 10 years |
| <input type="radio"/> 1 - 5 years | |

*A4. In a typical week, how many hours of direct patient care do you provide?

(Patient care includes seeing patients, reviewing tests, preparing for and performing surgical procedures, and providing other related patient-care services.)

- | | |
|-------------------------------------|--|
| <input type="radio"/> None | <input type="radio"/> 20 - 29 hours |
| <input type="radio"/> 1 - 9 hours | <input type="radio"/> 30 or more hours |
| <input type="radio"/> 10 - 19 hours | |

F: ELECTRONIC PRESCRIBING (eRx) INCENTIVE PROGRAM PARTICIPATION

*F1. Have you heard of the eRx program?

- Yes
 No

*F2. Are you a participant in the 2013 eRx program?

- Yes No, I am exempt.
 No

*F3. Which of the following influenced your decision to participate in eRx? *{Select all that apply.}*

- | | |
|--|---|
| <input type="checkbox"/> Believe it is important to continuously improve patient care | <input type="checkbox"/> Required by my practice/organization |
| <input type="checkbox"/> Incentives from private payers for participation in quality reporting initiatives | <input type="checkbox"/> To avoid Medicare penalty or reduction in payment |
| <input type="checkbox"/> Internal cost reduction effort | <input type="checkbox"/> To earn Medicare incentive payment for eRx |
| <input type="checkbox"/> Public reporting/transparency | <input type="checkbox"/> To prepare for a time when quality is a significant factor in Medicare reimbursement |
| <input type="checkbox"/> Other (please specify):
<input type="text"/> | |

*F4. What is the effect of eRx participation on coordination of care efforts with other practitioners within or outside of your practice?

- No effect A moderate effect
 A small effect A large effect

*F5. Please rate the extent that you agree that eRx participation has:

	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Helped me reduce the prescription of medication that is contraindicated or could cause adverse reactions for my Medicare patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Helped me improve the quality of care that I provide to my Medicare patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Improved the overall health for a majority of my Medicare patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Reduced avoidable health care costs for my Medicare patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Increased patient satisfaction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*F6. As a program participant, how likely would you be to recommend eRx to other practitioners?

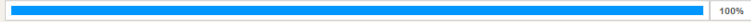
- Highly unlikely Somewhat likely
 Somewhat unlikely Highly likely
 Neither likely nor unlikely

*F7. Did you receive a penalty in eRx?

- Yes
 No
 No, I am exempt.

*F8. If yes, what year(s) was the penalty received? *{Select all that apply.}*

- 2012
 2013



J: CONCLUSION

*J1. Who completed the survey?

- The professional to whom the survey was addressed
- Administrative staff
- Other eligible professional
- Other (please specify):

*J2. We appreciate your feedback. Feel free to use this space to comment on the survey or program issues you would like to see addressed in future evaluations.

*J3. Please include your name, email, and phone number in case we have a question about your survey.

Title:	<input type="text"/>
First name:	<input type="text"/>
Last name:	<input type="text"/>
Phone number:	<input type="text"/>
Alternate phone number:	<input type="text"/>
Email:	<input type="text"/>

*J4. Would you like to receive the \$100 incentive that will be sent electronically to the email above?

- Yes
- No

J5. Are you willing to participate in a 30-minute follow-up phone interview to talk more about your reasons for your participation decision, if applicable, and your experiences with the PQRS/eRx program(s)?

You will receive an additional \$100 gift card if you participate in the phone interview in addition to completing this survey.

- Yes
- No

THERE ARE NO MORE QUESTIONS.

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY!