EMR Adoption Survey

Instructions

This survey contains a series of multiple-choice questions corresponding to the 5-stage EMR Adoption Model.

If the respondent is a physician, ask all questions. If the respondent is a medical office assistant, ask the questions which begin with **(MOA).**

1) For each question, select the choice that best describes the current situation or method used in the office.
2) If a response is in between two choices, circle both and assign a value in the middle (e.g. 2.5). Comment on the discrepancy between the stages.
3) Add any comments in the space provided under each question. Please flag any responses that require review and document in the comments section where the answer does not fit a known category.

To score the survey, use the EMR Adoption Survey Scoring Sheet.

Health Information and Data

Patient Demographics

1. **(MOA)** How do you keep track of the patient demographics in your practice?

☐	I store patient demographics in the **patient chart** and/or in my **billing program**.	0
☐	**Mainly** in the patient chart and **billing program**. I may have **some files** on my **computer** also, such as spreadsheet for some patients.	1
☐	My billing program is the main source for patient information, I also duplicate (manually) patient information in my EMR or other electronic tools I use.	2
☐		3
☐	**Exclusively** in my **EMR** (which has a integrated billing system)	4
☐	**Exclusively** in my **EMR** which can be **synchronized** with a **provincial electronic patient registry (provincial EHR)**	5

Comments:

Medical Summary

2. **(MOA)** Where do you keep a patient's medical summary?

☐	I maintain a **separate (face) sheet in** the **paper chart** that **I manually update or I do not maintain a patient medical summary**.	0
☐	I use my electronic system, which include(s) free-text information on some patients. (Not an EMR)	1
☐	I use my EMR which contain(s) free-text or structured information for ***some*** patients.	2
☐	I use my EMR which store(s) nearly all or *all* my patient records, but mainly as free-text.	3
☐	I use my EMR which store(s) all my patient information in a *structured* form. (For example: **standardized coded problem lists, medical history, medications, allergies, procedures, immunizations, etc.**)	4
☐	As in level 4, I use my EMR, which also syncs summary data with provincial EHR.	5

Comments:

Unstructured and Structured Patient Notes

3. How do you record your patient visit or encounter notes?

☐	**Written** entries in the **paper chart**	0
☐	**Dictated, transcribed** and inserted in the chart	1
☐	In my **EMR as text** that **I** enter notes for patient visits for only some of my patient visits (e.g. for patients with chronic disease) or we copy all transcribed notes into the EMR as free text.	2
☐	In my **EMR** as **text** that **I** enter in a **SOAP note or equivalent** for **all patient** visits, most of my findings and plans **I** type in as free text	3
☐	In my **EMR** using **multiple structure templates to enter data. (I capture findings as structured elements where feasible)**	4
☐	In my **EMR** using **multiple fields and templates** with selected data that can be **synchronized** with a **provincial EHR**	5

Comments:

Treatment Plans

4. How do you record treatment plans?

☐	**Written** entries in the chart	0
☐	Dictated, **transcribed** and **inserted** in the chart	1
☐		2
☐	In my **EMR** as text that **I** enter in the Plan section of a **SOAP note or equivalent**	3
☐	In my **EMR** where care plans are **coded as orders or other searchable field data**. Plans include **triggered activities** such as follow up reminders, etc.	4
☐	In my **EMR** where **I** can **contribute** to and manage care plans developed by a team of providers in an **Electronic Health record** that is part of **an integrated network**	5

Comments:

Provider Relationships

5. **(MOA)** How do you keep a list of other providers that you refer to (i.e. specialists)?

☐	Lists are **kept on paper** (e.g. in a printed directory, on a rolodex or other).	0
☐	I use my **billing program** to view a list or do a search or I have some other electronic list of providers that I refer to (e.g. electronic address book)	1
☐		2
☐		3
☐	As an **updated and managed list in my EMR** that **can be searched or selected** as part of the referral process	4
☐	As a **managed dataset in my EMR** that **is synchronized** and updated using a **provincial electronic provider registry**	5

Comments:

6. **(MOA)** How do you keep track of which providers a patient sees (e.g. specialists, home care nurses, physio)?

☐	Lists are **kept in paper chart or not at all**	0
☐	I use my **billing program** to view a list of who I have referred to in the past for that patient	1
☐		2
☐	I can look through my EMR to find who I have referred to and review names on consult letters, etc.	3
☐	My EMR has a specific list of providers that my patient sees. I maintain this and it is updated when I make referrals in my EMR.	4
☐	My EMR maintains a list and it synchronizes with the provincial EHR.	5

Comments:

Order Entry/Management

ePrescribing

7. How do you write new drug prescriptions?

☐	I **write** them on my **Rx pad** and **record** them in the **patient's paper chart**	0
☐	I **write** them on my **Rx pad** and **dictate** / **transcribe** them as **part of my note entry** for filing in the patient's paper chart	1
☐	I write them using my **EMR some of the time** then **print the Rx to give to the patient**.	2
☐	I write them for **all patients** using my **EMR**, which has an **updated formulary**, **keeps track of their medication lists** and **provides allergy alerts**. I **print the Rx** to **give to the patient**.	3
☐	I write them for **all patients** using my **EMR**, which has an advanced Rx module with **clinical decision supports** such as alerts for **drug:drug** and **drug:disease** interactions. Prescriptions are **still printed** or faxed.	4
☐	I write them for **all patients** using my **EMR** which has an advanced Rx module and is **linked to a province wide ePrescribe system** so I can **generate** an **electronic Rx** for the patient to **pick up at the specified pharmacy**	5

Comments:

8. **(MOA)** Describe your process for managing medication prescription renewals.

☐	Requests are **processed manually by fax or phone** and **recorded** in the patient's **paper chart**	0
☐		1
☐		2
☐	Requests are **processed manually by fax or phone** and I **record** that in my **EMR** (e.g. by creating a new prescription)	3
☐	Requests by **fax or phone** are **registered and sent by staff as an electronic request within my EMR for approval and sent back by fax or phone**	4
☐	Requests are **received, processed and approved electronically** from a **province wide ePrescribe system**, **linked to my EMR**	5

Comments:

Lab

9. How do you order lab tests?

☐	I use the standard **preprinted lab requisition form** and (may) **re-write** what I ordered in the **paper chart**	0
☐	I may use an **electronic version of the standard requisition** which I print out then **re-write** what I ordered in the **paper chart**	1
☐		2
☐	I use my **EMR**'s electronic **version** of the **standard, free-text lab requisition** which **automatically records** what I ordered **in the patient file**; then print out the requisition	3
☐	My **EMR** has a **lab requisition manager** that lets me **order tests**, **print out the form**, gives me some **clinical decision support** prompts, and **automatically records** and **reconciles** tests and results.	4
☐	As in #4, but my **EMR** can send orders and reconcile tests electronically. **No paper requisitions are generated**	5

Comments:

Medical Imaging

10. How do you order diagnostic tests? (i.e. x-rays, U/S, CT, MRI, PFT, Stress tests, etc)

☐	I complete a **paper requisition** specific to the diagnostic centre	0
☐	I may use an **electronic version** of the diagnostic centre specific requisition which **I print out and complete**	1
☐	I use a requisition as above, but manually scan in and / or document that I ordered the test in my EMR for some patients.	2
☐	I use a requisition as above, but manually scan in and / or document that I ordered the test in my EMR for all patients.	3
☐	My **EMR** has a **diagnostic requisition manager** that lets me **order tests**, **prints the order form**, gives me some **clinical decision support** prompts, and **automatically records and reconciles** the order and subsequent report.	4
☐	I use an **advanced diagnostic test requisition manager** in my **EMR** that is **securely linked** to **diagnostic test sites** so I can **order**, **record and reconcile** tests **electronically**. No paper requisitions are generated	5

Comments:

Referrals

11. **(MOA)** How to you make a referral?

☐	**I hand write** the referral letter. My **MOA calls** to make the **appointment.**	0
☐	I use a **computer** / word processor to generate the referral letter. My **MOA calls** to make the **appointment**	1
☐	I use a **computer** / word processor to generate the referral letter. My **MOA calls** to make the **appointment. The office tracks referrals** in a computer application **(not and EMR)**	2
☐		3
☐	I use my **EMR's referral manager**, which has an **updated database of consultants** and the ability to **generate and fax a referral letter using selectable data from the patient record**. My **MOA calls** to make the **appointment**	4
☐	I use my **EMR's referrals manager**, which **is linked on a secure network with consultants** located in private offices and/or hospitals. The **consultant can view referral** data when an **electronic request** is sent. Referral **appointments** can be **made online within the network**	5

Comments:

Results Management

Lab

12. How do you receive, review and process on lab results?

☐	Lab reports of tests I ordered (or were copied to me) are received **in paper form by mail and/or fax** and filed in the patient chart. Written follow up instructions are given to my MOA if needed	0
☐	I also **view and print some lab reports electronically through software from the laboratories or a web interface** and file them in the patient chart in the same way as paper reports	1
☐		2
☐	**Most** lab results are **downloaded** into a **structured database** in my **EMR** to allow **viewing in tabular and graphic formats**. Results of tests that I ordered (or were copied to me) are reviewed and signed off from my inbox after sending follow up instructions to my MOA as needed. **Some lab reports** are still only **stored as scanned documents** (non structured)	3
☐	**ALL lab results** of tests I ordered (or were copied to me) from multiple lab facilities are **downloaded into a structured database in my EMR** for viewing and processing	4

☐	**All lab results** of tests that I ordered (or were copied to me) are **downloaded into my EMR**, which also **has a viewer** to **integrate** and display all available lab data on a patient **from multiple lab databases and hospitals**.	5

Comments:

Medical Imaging

13. How do you receive, review and process X-ray reports?

☐	**Received in paper form** by mail and/or fax and filed in the patient chart after written follow up instructions are given to my MOA if needed	0
☐	I can also **view** images and **print** the reports from a **web interface or diagnostic imaging viewer** or on **CD** and file them in the patient chart in the same way as paper reports	1
☐		2
☐	**Paper X-ray reports are scanned,** loaded and **linked to the patient database in my EMR** then reviewed and signed off from my inbox after sending follow up instructions to my MOA as needed	3
☐	X-ray reports are **digitally downloaded** into a **structured database in my EMR**, reviewed and signed off from my inbox after sending follow up instructions to my MOA as needed	4
☐	X-ray reports are **digitally downloaded** into a **structured database in my EMR** which also has a **viewe**r to **integrate** and display all available diagnostic images and reports on a patient from **multiple DI facilities**	5

Comments:

Consults

14. **(MOA)** How do you receive and process consultation reports?

☐	Received in paper form by **mail and/or fax** and filed in the patient chart after written follow up instructions are given to my MOA if needed	0
☐	I can also **scan some** paper consult reports in a **standalone PC** for electronic access	1
☐	Paper consult reports are **scanned**, loaded and **linked to the patient database in my EMR** then reviewed and signed off from my inbox after sending follow up instructions to my MOA as needed	2
☐	**Some** Consult reports are **digitally downloaded or copied** into my **EMR** as **simple text letters**, reviewed and signed off from my inbox after sending follow up instructions to my MOA as needed	3
☐	**Most or all** Consult reports I receive are **digitally downloaded** into my **EMR** as **letters**, reviewed and signed off from my inbox after sending follow up instructions to my MOA as needed	4

☐	Consult reports are **digitally downloaded** into a **structured database** in my **EMR** and this can **update my problem lists**, **medications and other summary data in my EMR**.	5

Comments:

Decision Support

Reference Material and Patient Handouts

15. How do you store and access reference materials including patient handouts?

☐	I use only **paper based handouts** and keep photocopies in the office	0
☐	I can also use the **web** or other **standalone software on a PC or handheld** device	1
☐		2
☐	**Website links** and/or **reference databases** are **accessible from within my EMR,** from its user interface (e.g. the menu bar) but are not patient specific.	3
☐	**Website links and/or reference databases** can also be **accessed from a patient's file based on specified data elements** such as diagnoses, problems, lab results, meds, specific templates, etc.	4
☐	Information available from updated **reference databases** that **reflect local (Health Authority or Provincial) expertise and policies** is **accessible from general** and **patient specific user interfaces in my EMR**	5

Comments:

Medication Alerts

16. How are you alerted of potential drug allergies and interactions when writing or renewing a prescription?

☐	Only by **reading a medication's drug profile** (e.g. in the CPS) **or phoning a pharmacist**.	0
☐	I use a **standalone PC** or handheld to manually check drug: drug interactions	1
☐	I use an **EMR** that provides **basic recommendations** such as **drug dose** and **frequency**	2
☐	I use an **EMR** that **automatically** provides **drug:drug** and **drug:allergy** alerts	3

☐	I use an **EMR** with more **comprehensive** drug alerts including **drug:disease**, **drug:lab** to check against the local medication list in the EMR.	4
☐	I use am **EMR** with an **integrated clinical decision support system** (CDSS) that is **linked** to **updated provincial** as well as **local medication lists**	5

Comments:

Reminders – Manual and Automatic

17. **(MOA)** How are patient reminders (for follow up and prevention) generated in your office?

☐	**Manually** each time I check the paper chart when I see a patient **I record** any **follow up in the patient's chart**.	0
☐	I also use a **personally setup, standalone reminder system (i.e. Excel spreadsheet) or my office's billing program**, which has reminders.	1
☐	I use an **EMR** that allows **me to set up** recall reminders for an individual or groups of patients	2
☐	I use an **EMR** that also has **built-in automated reminders** for prevention (that I cannot add to)	3
☐	I use an **EMR** with a **customizable rule based reminder** system that searches a **structured database** allowing **me to setup multiple reminders** using different parameters and reminds me of overdue reviews based on common conditions.	4
☐	I use an **EMR** with a **rules based reminder** system that also **leverages** information on **provincial and other external repositories** to adjust rules	5

Comments:

Chronic Disease Management

18. What system do you use to manage your patients with chronic diseases (i.e. diabetes, hypertension, COPD, etc)?

☐	**No** formal chronic disease management **system**	0
☐	I use **flow sheets** on paper which are part of the **paper chart**	1
☐	I use the **Provincial CDM Toolkit** but data must still be **entered manually** on a regular basis	2
☐	I use an **EMR** that **has flow sheets,** it **does not have recall lists, etc.**	3
☐	I use an **EMR** that **has flow sheets generated from structured data** from which **reminders and recall lists can be generated**. i.e. my EMR has similar functionality to the CDM Toolkit.	4

☐	I use an **EMR** with **integrated flow sheet data** with **contributions from multiple providers** and repositories **across a secure network** from which **reminders and recall lists are generated**	5

Comments:

Clinical Practice Guidelines (CPGs)

19. How are clinical practice guidelines used in providing patient care in your practice?

☐	I use **paper-based guidelines** and review them when I need to.	0
☐	I also use a **standalone PC** or handheld to look up guidelines when I need to.	1
☐		2
☐	I use an **EMR** with access to guidelines that I can read (e.g. there are links to guidelines in the EMR)	3
☐	I use an **EMR** that **has templates and reminders.** The **CDM flow sheets** / **templates have embedded guidelines**. My EMR has reminders for follow up.	4
☐	I use an **EMR** that has **embedded guidelines updated from external sources** to **automatically adjust** best recommendations	5

Comments:

Electronic Communication and Connectivity

Intra-office Communication

20. **(MOA)** How do you communicate about patient issues in your office (e.g. between providers, between providers and staff)?

☐	We **talk** in my office / on the phone. **Paper notes** are stuck to the front of the chart and left on my desk or in an inbox for review.	0
☐	**Paper** and **sometimes a secure tool like email** (NOTE: NOT part of the patient chart but can be printed to put in the paper chart).	1
☐	**Standalone secure communication tool (e.g. secure email**) used for the majority of community. **Not part of the paper chart**.	2

☐	**Secure electronic communication tool as part of the EMR** used by **some providers** and the **messages** are **tagged** to the patient's **EMR record**.	3
☐	**Secure electronic communication tool as part of the EMR** used frequently by all providers in the office and the **messages** are **tagged** to the patient's **EMR record**.	4
☐		5

Comments:

External and Cross-Organizational Communication

21. **(MOA)** How do you communicate about patient issues with providers OUTSIDE office (e.g. specialists, hospital), not including formal referrals?

☐	For the majority of communication, it is by **phone** / **fax**. It is kept / **documented** in the **paper chart**	0
☐		1
☐	Any communication is **scanned into the EMR**.	2
☐	**Standalone, secure electronic communication (e.g. secure email**) used in my community for most of my external communication.	3
☐	I use my **EMR** to **generate outgoing notes**, which are **printed and faxed**. **Alternatively,** I use a **standalone tool** for **all communication** and I **cut and paste** everything into my **EMR**. **All notes** are stored **in** my **EMR**.	4
☐	We have an **electronic communication network** for much of the communication that is **connected to my EMR**. **Messages arrive** in my inbox from others **electronically** (e.g. are not scanned).	5

Comments:

Patient Support

22. **(MOA)** How do you share information with your patients? (both patient data and handouts / general information)

☐	Provide **paper copies of results** when asked and have handouts photocopied for common problems	0
☐	I use the **internet** for handouts when I need them	1

☐	Our **practice** / group **has** a **website** with patient handouts and /or links to good resources for our patients	2
☐	Our practice uses **secure email** with patients for some activities, such as scheduling appointments, requesting refills (NOTE: flag if unsecure email is used).	3
☐	Our **EMR** has a **patient portal**. Patients can **view some** of their **data** online and / or they can communicate with us to request appointments, etc.	4
☐	Our **EMR** can **send data** to our **patients' Personally Controlled Health Record** (e.g. Google Health). This is used by at least 20% of patients in the practice	5

Comments:

Administrative Processes

Scheduling

23. **(MOA)** How do you schedule appointments for patients in the practice?

☐	We have a paper scheduling system for the practice	0
☐	We have an electronic standalone scheduling system for the practice (NOTE: may / may not be part of the billing program).	1
☐	We have an EMR with scheduling, but the electronic day sheet is only visible to office staff, clinicians (e.g. physicians) review a paper print out of the schedule.	2
☐	We have an EMR and the scheduling is used by both front staff and clinicians to see the status of patients in the schedule.	3
☐	We use our EMR scheduler for complex scheduling, including document visit types and / or reason for visit, this is linked to the patient's electronic record.	4
☐	Other people, outside of our office, request or schedule appointments electronically into our EMR for at least some visits (e.g. patients schedule directly or family physicians can book referrals directly)	5

Comments:

Billing

24. **(MOA)** How do you bill in the practice?

☐	I write my billings on paper and send them to a billing service (I do not know what they use) or I submit on paper.	0
☐	I write my billings on paper and the office staff (or I directly) use an electronic billing system to submit and manage the bills.	1
☐	I write my billings on paper and the office staff use our EMR to submit and manage the bills. (NOTE: we may not use our EMR as a full EMR yet.)	2
☐	I use the billing module in my EMR directly to add codes for visits and my office staff reviews and manages payment through the EMR	3
☐	I use my EMR and it autopopulates the billing codes based on my notes in the patient's chart, which can be edited / added to and then managed within the EMR.	4
☐		5

Comments:

Reporting and Population Health Management

25. **(MOA)** How do you manage chronic conditions across your practice? Do you have any recall lists or disease registries, for example?

☐	We have **paper lists and calendars** where we put recalls for mammograms, etc. and we **rely** on the **provincial programs** for recalls.	0
☐	We use our **billing program** to run reports for patients who are overdue for chronic disease visits / immunizations.	1
☐	We have our own **spreadsheet or database** to track some of our chronic disease patients **or** we use **another standalone tool**, such as the **CDM toolkit** (in BC) that is **not linked to our EMR**	2
☐	Our **EMR** can run reports of patients with specific diagnoses. The **reports are built in** (we do not run our own). Alternatively, we upload patient data from our EMR to an external site (such as the BC CDM toolkit).	3
☐	We have **complex reports** in our **EMR** that we use (i.e. diabetics with A1c over 8% who haven't been seen in 3 months) and **we create our own reports**.	4
☐	As in #4, but the **report queries** used **also include additional data from regional** / **provincial systems** in some way.	5

Comments: