Rural Health Clinic Grant
Electronic Health Records (EHR) Questionnaire

Provider/Group Name: _____

TAX ID: _____ Provider/Group NPI: _____

Address: _____

Phone Number:_____ Fax Number:_____ Email Address:_____

Region:_____ County: _____MMA Assigned Membership Count: _____

EMR/EHR PLANNING

Do you currently have an EHR system? ☐ Yes ☐ No

If you have not implemented an EHR system, please indicate why. Please prioritize in order with '1' being the most important and '10' being the least important.

___ / Unable to secure all partners' commitment

___ / Financial Constraints

___ / Vendor support was inadequate for technical needs

___ / Vendor stability and viability

___ / Software requires extensive customization to fit into clinic intensive

___ / Initial data entry is too labor

___ / Already spending additional hours at office daily

___ / Difficult to select a system

___ / Do not know where to begin

___ / Other_____

1. If you have an EHR system,
    a. Which system and version do you have? _____
    b. When was the last time you completed a thorough Security Risk Assessment? _____
    c. Do you have HIPAA Policies and Procedures in place to protect your systems and patient data? _____
    d. When was the last time you did penetration testing (network scans) to identify open ports through which viruses, or hackers could compromise your electronic patient health information (ePHI)? _____
    e. Are you using that system to run reports for (check all that apply)?

        ☐ Meaningful Use attestations
        ☐ MIPS/MACRA attestations
        ☐ Patient Centered Medical Home recognition submissions
        ☐ Other _____

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f. Are you planning to add additional modules (PCMH, Telehealth, etc.) to your EHR system? If so, which ones?

_____

2. Are you planning to use wireless technology? ☐ Yes ☐ No
3. Do you plan to use wireless hand-held units? ☐ Yes ☐ No.
4. Will you be implementing in a modular fashion? ☐ Yes ☐ No.
5. Do you have servers in your office? ☐ Yes ☐ No
6. Do you have T1, Cable Modem, Fiber Optic, or Dial-up connection in place? ☐ Yes ☐ No
7. If yes, please indicate type of connectivity and provider. _____
8. Do you plan to share patient information with other physicians? ☐ Yes ☐ No
9. Do you plan to share information with other hospitals? ☐ Yes ☐ No
10. Do you currently scan in any information? ☐ Yes ☐ No
11. If yes, please indicate types of information._____
12. Do you intend to scan documents into the EHR? ☐ Yes ☐ No
13. What information do you want to be scanned in the EMR system? ☐ Yes ☐ No
14. Will your clinic want Patient History data pre-loaded? ☐ Yes ☐ No
15. If yes, what duration? ☐ current year ☐ two years ☐ more than two years
16. If yes, who will be responsible for pre-loading this data prior to the first patient visit recorded in the EHR? (circle all that apply)
    - ☐ PA or NP:
    - ☐ Nurse:
    - ☐ Other (specify): _____
17. Has the clinic reviewed any EHR vendors? ☐ Yes ☐ No
18. Has the clinic seen any EHR vendor demos? ☐ Yes ☐ No
19. Has a budget for the EHR system been established? ☐ Yes ☐ No
20. If yes, does it include projected costs for hardware and services? ☐ Yes ☐ No
21. If yes, does it include ongoing maintenance and version updates? ☐ Yes ☐ No
22. Who will be designated as Site Administrator? (This person will be responsible for assigning access and security privileges to staff.) (circle which applies)
    - ☐ Physician
    - ☐ Nurse
    - ☐ Office Manager
    - ☐ Other (specify): _____

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23. Will providers or other staff need to access the database from remote locations, home, the hospital, other? _____ affiliated sites? ☐ Yes ☐ No
24. Is there any remote access currently supported in the clinic? ☐ Yes ☐ No
25. If yes, please explain_____
26. Is the clinic planning to use workstations in the exam rooms? ☐ Yes ☐ No
27. Is the clinic planning to implement a wireless network, use tablet PC's, laptops or PDA's? ☐ Yes ☐ No
28. How soon do you anticipate purchasing a system? Indicate Timeframe: _____
29. Do you have a preference when you would like to begin the implementation? ☐ Yes ☐ No
30. Do you have a go-live date in mind? Indicate date: _____
31. What goals do you expect to achieve with an EHR? What benefits do you hope to realize?

Please check all that apply:

☐ Reduce transcriptions costs

☐ Reduce paper based medical charts and filing charts

☐ Reduce administrative costs associated with clinic

☐ Provide more services to patients per visit

☐ Capture all services provided at each visit

☐ Receive return on investment associated with software/hardware

☐ Improve phone and fax processing

☐ Timely access to patient records

☐ Other. Please explain:

_____

_____

Grant Recipient Attestation

As a recipient of Aetna Better Health of Florida's (ABH) Electronic Medical Record (EMR) Grant, I attest that any funds issued by ABH will be used exclusively to promote enhancements of EMR system. I understand that ABH may request, at any time, evidence that grant funds have been used exclusively for this purpose.

Signature: _____

Printed Name:_____

Title: _____

Date: _____