ICPSR | INTER-UNIVERSITY CONSORTIUM FOR POLITICAL AND SOCIAL RESEARCH

ICPSR 31482

National Ambulatory Medical Care Survey, 2009

United States Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Health Statistics

Electronic Medical Records Supplement Form

Inter-university Consortium for
Political and Social Research
P.O. Box 1248
Ann Arbor, Michigan 48106
www.icpsr.umich.edu

Terms of Use

The terms of use for this study can be found at:
http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/31482/terms

Information about Copyrighted Content

Some instruments administered as part of this study may contain in whole or substantially in part contents from copyrighted instruments. Reproductions of the instruments are provided as documentation for the analysis of the data associated with this collection. Restrictions on "fair use" apply to all copyrighted content. More information about the reproduction of copyrighted works by educators and librarians is available from the United States Copyright Office.

NOTICE
WARNING CONCERNING COPYRIGHT RESTRICTIONS

The copyright law of the United States (Title 17, United States Code) governs the making of photocopies or other reproductions of copyrighted material. Under certain conditions specified in the law, libraries and archives are authorized to furnish a photocopy or other reproduction. One of these specified conditions is that the photocopy or reproduction is not to be "used for any purpose other than private study, scholarship, or research." If a user makes a request for, or later uses, a photocopy or reproduction for purposes in excess of "fair use," that user may be liable for copyright infringement.

OMB No. 0920-0234: Approval expires 08/31/2009

NOTICE - 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: CDC/ATSDR Information Collection Review Office; 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0234).

Assurance of Confidentiality - All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

National Ambulatory Medical Care Survey (NAMCS):

Electronic Medical Records Supplement 2009

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*?

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

	Yes, all electronic	Yes, part paper and part electronic	No	Unknown
16. Does the reporting location submit *claims* electronically *(electronic billing)?*	1☐	2☐	3☐	4☐
17. Does the reporting location use electronic *medical* records or electronic *health* records (EMR/EHR)? Do not include billing records.	1☐	2☐	3☐	4☐

18. 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
18a. Patient demographic information?	1☐ *Go to 18a1*	2☐ *Skip to 18b*	3☐ *Skip to 18b*	4☐ *Skip to 18b*
18a1. If yes, does this include a patient problem list?	1☐	2☐	3☐	4☐
18b. Orders for prescriptions?	1☐ *Go to 18b1 & 18b2*			4☐ *Skip to 18c*
18b1. If yes, are there warnings of drug interactions or contraindications provided?	1☐	2☐	3☐	4☐
18b2. If yes, are prescriptions sent electronically to the pharmacy?	1☐	2☐	3☐	4☐
18c. Orders for tests?	1☐ *Go to 18c1*	2☐ *Skip to 18d*	3☐ *Skip to 18d*	4☐ *Skip to 18d*
18c1. If yes, are orders sent electronically?	1☐	2☐	3☐	4☐
18d. Viewing lab results?	1☐ *Go to 18d1*	2☐ *Skip to 18e*	3☐ *Skip to 18e*	4☐ *Skip to 18e*
18d1. If yes, are out of range levels highlighted?	1☐	2☐	3☐	4☐
18e. Viewing imaging results?	1☐ *Go to 18e1*	2☐ *Skip to 18f*	3☐ *Skip to 18f*	4☐ *Skip to 18f*
18e1. If yes, can electronic images be returned?	1☐	2☐	3☐	4☐
18f. Clinical notes?	1☐ *Go to 18f1*	2☐ *Skip to 18g*	3☐ *Skip to 18g*	4☐ *Skip to 18g*
18f1. If yes, do they include medical history and follow-up notes?	1☐	2☐	3☐	4☐
18g. Reminders for guideline-based interventions or screening tests?	1☐	2☐	3☐	4☐
18h. Public health reporting?	1☐ *Go to 18h1*	2☐ *Skip to 19*	3☐ *Skip to 19*	4☐ *Skip to 19*
18h1. If yes, are notifiable diseases sent electronically?	1☐	2☐	3☐	4☐

19. At the reporting location, are there plans for installing a new EMR/EHR system or replacing the current system within the next 3 years?

☐1 Yes
☐2 No
☐3 Maybe
☐4 Don't know

*If the reporting location **does not have an EMR/EHR system**, SKIP TO QUESTON 22.*

*If the reporting location **has an EMR/EHR system**, CONTINUE BELOW TO QUESTIONS 20 & 21.*

20. What year did you last buy or upgrade your EMR/EHR system?

_____

21. Is your EMR/EHR system certified by the Certification Commission for Healthcare Information Technology (CCHIT)?

☐1 Yes
☐2 No
☐3 Don't know

22. Are you a full- or part-owner, employee, or an 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.

Boxes for Admin Use