

APPLICATION FOR FEE SCHEDULE INCREASE TO PRIMARY CARE PHYSICIANS USING QUALIFIED ELECTRONIC HEALTH RECORDS

Section B: Electronic Health Records¹

1. Does your main practice have EHR components? By EHR components, we mean an integrated electronic clinical information system that tracks patient health data, and may include such functions as visit notes, prescriptions, lab orders, etc.

☐ **No** → (Skip to question 10 on page 4)

☐ **Yes** → (This information is confidential.)

a. Vendor name: _____ Version: _____ (If the vendor name and version number is not provided, the application will be deemed incomplete).

b. When did your practice install an EHR? _____

c. Does your EHR have Office of the National Coordinator (ONC) Complete Certification? (This includes CCHIT, Drummond, and other certifications.) If you are unsure, please view the ONC's database of certified products at <http://www.onc-chpl.force.com/ehrcert>.

☐ **No**

☐ **Yes**

2. Do you plan to seek incentive payments, also called [Meaningful Use](#) reimbursements? (Choose one.)

☐ Yes, from Medicaid's EHR Incentive Program

☐ Yes, from Medicare's EHR Incentive Program

☐ Yes, but I have not chosen between the Medicare and Medicaid EHR Incentive Programs yet

☐ No, I do not plan to seek incentive payments

☐ No, I do not qualify for either the Medicaid or Medicare EHR Incentive Program

☐ Don't know

☐ Need more information

(Comments?) _____

3. When do you plan to submit your attestation for Stage 1 Meaningful Use?

☐ 2011

☐ 2012

☐ After 2012

For the following eight questions, please indicate the proportion of time during which you use the following EHR features in your main practice when they are applicable to a particular patient or situation.

1. Please indicate the extent to which you use the following DEMOGRAPHIC functionality.

	0%	<30%	30%-60%	>60%	N/A
Patient demographics (e.g., address, phone numbers, date of birth, gender)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**APPLICATION FOR FEE SCHEDULE INCREASE TO PRIMARY
CARE PHYSICIANS USING QUALIFIED ELECTRONIC HEALTH RECORDS**

2. Please indicate the extent of time during which you use the following CLINICAL DOCUMENTATION functionalities as patients are seen in your office.

	0%	<30%	30%-60%	>60%	N/A
Electronic visit notes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Electronic lists of each patient's medication	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Electronic problem lists	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Patient clinical summaries for referral purposes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

3. Please indicate the extent of time during which you use the following CLINICAL DOCUMENTATION functionalities when you are not in your office and need access to clinical information.

	0%	<30%	30%-60%	>60%	N/A
Remote access to medication lists	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Remote access to problem lists	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

4. Please indicate the extent to which you use the following INTEROPERABILITY functionality.

	0%	<30%	30%-60%	>60%	N/A
Electronic referrals or clinical messaging (secure emailing with providers outside your office)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

5. Please indicate the extent of time during which you use ORDER MANAGEMENT functionalities.

	0%	<30%	30%-60%	>60%	N/A
Laboratory order entry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Medication order entry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Radiology order entry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

6. REPORTING functionalities can be used to generate clinical quality measures, identify patients with a given condition, characteristic, or risk factor, and track patients out of compliance with clinical guidelines.

Are you producing any patient population reporting from your EHR?

☐₁ Yes (*complete questions 6a and 6b*) ☐₂ No (*skip to question #7*)

6a. How frequently are you producing the patient population reporting?

☐₁ Daily ☐₂ Weekly ☐₃ Monthly ☐₄ Quarterly ☐₅ N/A

6b. Use the space below to describe the reporting you are performing. Please name, at a minimum, one specific clinical quality measure report, the numerator, denominator, and percentage result for the measure.

**APPLICATION FOR FEE SCHEDULE INCREASE TO PRIMARY
CARE PHYSICIANS USING QUALIFIED ELECTRONIC HEALTH RECORDS**

7. Please indicate the percentage of time during which you use the following RESULTS MANAGEMENT functionalities when receiving patients in your office.

	0%	<30%	30%-60%	>60%	N/A
Laboratory test results directly from lab via electronic interface	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Scanned paper laboratory test reports	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Manual data entry of laboratory test results	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Radiology test results directly from facility via electronic interface	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Scanned paper radiology test reports	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Manually data entry of radiology test results	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

8. Please indicate the extent of time during which you use the following OTHER functionalities, when they are applicable to a particular patient or situation.

	0%	<30%	30%-60%	>60%	N/A
Drug interaction warnings at the point of prescribing	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Letters or other patient reminders regarding indicated or overdue care	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
Prompts to providers at the point of care, regarding indicated care specific to the patient's condition(s)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

9. What percentage of time do you transmit prescriptions electronically to the pharmacy? (Includes computer-based faxing.)

- ☐₁ **0%**
☐₂ **<30%**
☐₃ **30%-60%**
☐₄ **>60%**



Do you transmit these prescriptions using an EHR? (*Check one*)

☐₁ **No**

☐₂ **Yes**

10. Please use this space to provide additional comments about your EHR use.

**APPLICATION FOR FEE SCHEDULE INCREASE TO PRIMARY
CARE PHYSICIANS USING QUALIFIED ELECTRONIC HEALTH RECORDS**

Blue Cross & Blue Shield of Rhode Island
Primary Care Physician Electronic Health Record
Fee Increase Attestation

The undersigned ("Provider") declares that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this application and any attachments or information submitted to BCBSRI in connection with this application, herein referred to as the "Application" are true and complete.

BCBSRI is authorized to make any inquiry or audit to establish the authenticity of the results of this survey.

If the information in this Application materially changes following submission, the Provider will immediately notify BCBSRI, and shall complete a new survey.

BCBSRI may retroactively withdraw any fee increase in its entirety if the results are subsequently found to not have met the fee increase criteria, and may retroactively recovery any fee increase to the date of change where materially changed results no longer meet the fee increase criteria.

Signed: _____ Date: _____

Print Name: _____

Type 1 National Provider Identifier (NPI) Number: _____

Tax Identification Number (TIN): _____

Please complete and mail this Application to:

Blue Cross & Blue Shield of Rhode Island
Attn: Provider Relations
500 Exchange Street
Providence, RI 02903

ⁱ EHR questions adapted with permission from: (1) Simon et al. Physicians and electronic health records: A statewide survey. *Arch Intern Med* 2007; 167: 507-512; and (2) Simon et al. Correlates of electronic health record adoption in office practices: A statewide survey. *J Am Med Inform Assoc* 2007; 14: 110-117.