REACH
West Pennsylvania East
Regional Extension & Assistance Centers for HIT

Eligibility Screening Form

Date_____ Completed by_____

Practice Name _____

Specialty _____

Practice Contact _____Phone_____ Email_____

Physician Champion _____ Email _____

Is your practice owned by a hospital system or other organization? _____

If Yes, name of organization _____

Billing Tax ID_____   Organizational NPI_____

Main Location Address

Street, City, State, ZIP

_____

_____

Telephone _____ Fax _____ Email _____

Number of Practice Locations _____

Main admitting hospital (if any) _____

Practice Demographics

Number of staff at this site

MD/DO	_____	CRNP	_____	PA	_____
RN/LPN	_____	MA	_____	CNM	_____
Non-Clinical.	_____				

<u>Based on office visits only</u>:

The # of individuals seen per previous calendar year _____
(For example, if Mrs. Smith is seen 3 times in 2009, she counts as 1 individual)

The # of encounters per year_____
(The # of claims billed in previous calendar year)

Have you explored the financial resources necessary to implement an electronic health record (EHR)
within the next 3 to 6 months?   ❒ Yes   ❒ No

Percent of Patients- List percentages in last 12 months

Payer Type	Organization %	Site %
Medicaid		
Medicare		
Managed Care		
Private Insurance		
Uninsured		
Other		

Approximate percentage of patients with one or more chronic illness _____

<u>Use of Technology</u>

❒ High speed internet connection
❒ Patient portal
❒ Electronic links with hospital/labs
❒ E-prescribing (Freestanding)
❒ Email
❒ Voice recognition/Dictation
❒ Practice website
❒ Online patient form completion
❒ Patient care registry

<u>Current Practice Management System:</u>

1. What is the name of your system (including version)? _____

2. When was your system purchased?   (Month/Year) _____

3. When was your practice management system implemented?   (Month/Year) _____

4. What functionalities of your PM system are you using?
    - ❐ Electronic scheduling
    - ❐ Electronic billing
    - ❐ Web-based scheduling
    - ❐ Other

If you do not have an EHR system:

1. Do you have access to a high speed internet/broadband connection?　　❐ Yes　　　❐ No

2. Have you explored any EHR systems?　　❐ Yes　　　❐ No

    If yes, how have you gone about it?
    - ❐ Read articles
    - ❐ Spoke to/visited colleagues who use EHR
    - ❐ Looked at EHR systems on-line
    - ❐ Viewed vendor demos in office

3. What do you feel your major needs for assistance will be in selecting and implementing an EHR? (check all that apply)
    - ❐ Assessment of practice needs
    - ❐ Identifying appropriate software vendors to review based on practice needs
    - ❐ Determining hardware needs
    - ❐ Assessing vendor proposals
    - ❐ Ensuring that system selected will support practice in meeting "meaningful use" requirements
    - ❐ Vendor negotiations
    - ❐ Redesigning workflow
    - ❐ Support during transition
    - ❐ Assistance with meeting "meaningful use" requirements

If you have an EHR system:

1. What is the name of your system (including version)? _____

2. When was your system purchased? ___(Month/Year)_____

3. When was your EHR system implemented? ___(Month/Year)_____

4. What functionalities of your EHR system are you using? (check all that apply)

   - ❐ E-prescribing
   - ❐ Lab results
   - ❐ Medication lists
   - ❐ Patient notes/documentation
   - ❐ Disease management/health maintenance
   - ❐ Drug/drug drug/allergy functionality
   - ❐ Results tracking/compliance with ordered tests
   - ❐ Internal messaging and task assignment tracking
   - ❐ Patient education module

❑ Coding support
❑ E-superbills

Use of Data

1. Do you participate in PQRI or other payor quality reporting programs?   ❑ Yes   ❑ No

   If yes, which programs?
   ❑ Governor's Chronic Care Initiative
   ❑ NCQA Patient Centered Medical Home, etc.

   If yes, how is the data submitted for this program?
   ❑ Claims-based
   ❑ Registry
   ❑ Paper
   ❑ Other

2. Does your practice conduct internally driven patient care initiatives?   ❑ Yes   ❑ No
   (Please identify initiatives)

_____

_____

Return to_____

Via email to: _____@wvmi.org

Via Fax: 610-265-3909

Coordinator Use Only: Confirm Organization Type- Circle One

Private Practice (1-10)

Public Hospital

FQHC

CHC

CAH

Rural Hospital

Private Practice (11 +)

Non-Priority Hospital

Other: _____