Attachment A
UPMC PRACTICE SOLUTIONS - MEDCHART & MEDLINK PRACTICE ASSESSMENT

www.medchart.info.com
1-866-648-8483

Practice Name:	**Specialty:**
Main Contact Office Phone:	**Main Contact** Office Fax:
Office Manager Name:	Office Manager e-mail: Office Manager cell:
Number of Providers: **Physician Name:** **Credentials:** **Specialty:** **Additional Provider (PA, CRNP):** **Name:** **Credentials:**	
Physician Champion e-mail:	Physician cell:

Date Contacted: **Referred by:** **Presentation Date:** **Timeframe for Implementation: _____**

Practice Address(es)/locations: Please list all practice locations

Location 1 **Number of providers:** Street: **Number of exam rooms:**	**Phone/Fax:** State: Zip:
Location 2 **Number of providers:** Street: **Number of exam rooms:**	**Phone/Fax:** State: Zip:
Location 3 **Number of providers:** Street: **Number of exam rooms:**	**Phone/Fax:** State: Zip:

Please list the Hospital(s) where you currently have Medical Staff Privileges:	
➢	➢
➢	➢
➢	➢

Are you currently part of the UPMC Health Plan Provider Network? ☐ **Yes** ☐ **No**

Are any of your providers currently employed by any Hospital/Health System? ☐ **Yes** ☐ **No**

If Yes- By whom?

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Specialty:

☐ **Internal Medicine**	☐ **Endocrinology**	☐ **Surgery**
☐ **Family Practice**	☐ **Gastroenterology**	☐ **Surgery- General**
☐ **Cardiology**	☐ **Geriatrics**	☐ **Surgery- GI**
☐ **Urology**	☐ **Nephrology**	☐ **Surgery- Oncology**
☐ **Orthopaedics**	☐ **OB-GYN**	☐ **Surgery- Vascular**
☐ **Dermatology**	☐ **Opthalmology**	☐ **Surgery- Bariatrics**
☐ **Ear, Nose & Throat (ENT)**	☐ **Rheumatology**	☐ **Surgery- Heart, Lung, ESI**
☐ **Psychiatry**	☐ **Pediatrics**	☐ **Surgery- Orthopedics**
☐ **Oncology**	☐ **Transplant**	☐ **Surgery- Plastics**
☐ **Other-please specify**		

PRACTICE SUMMARY:

# of Practice Tax IDs for Billing Purposes:	Do you currently have an EMR? Which Product?
# of Practitioner Names for Billing Purposes:	How is billing managed currently**?**
# Full Time Providers:	**If outside billing – how do you send charges, patient demographic information?** **Faxed?** **Picked up by billing service?** **Superbills utilized?**
# Part Time Providers (<20 hrs/week):	Current claims clearinghouse(s):
# Mid-Level Providers (NPs, PAs): CRNPs_____ PAs_____ NPs	Who will do billing after EHR?
# FTE Non-Provider Staff: MA_____ RN _____ LPN _____Other Staff _____	Would like to do billing in-house, onsite?
# of Part Time (PT) Non-provider employees Hours worked:	Current PMS/Version | Keep or Replace?
ASP Or Client Server Undecided	**How does your practice currently schedule patients? Please be specific.**
Currently dictating notes?	Does staff have necessary computer skills?
Interested in Speech Recognition?	**How Would you rate your staff's computer skills? 1-poor to 5- excellent?**

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Additional Practice Considerations:

1. **Do you plan on moving within the next year?**
2. **Do you plan on adding sites?**

3. **Do you plan on remodeling in the near future?**

4. Where do you admit most of your patients?
   a. Hospital Name(s):
   b. What % of patients do you admit to each?
   c. **Identify other places of service – nursing home/home visits/hospital outpatient procedures/hospital inpatient procedures/hospital inpatient surgeries/Home health care/radiology/etc.**

5. **Please provide an approximate number of "active" patients paper charts on site: _____**
6. **How many years of active patient paper charts are kept on site? _____**

7. **What additional Ancillary on-site services do you provide?**

   a. **Lab/Radiology?**
   b. **Other?**

Patient Demographics:

8. Average # of patients seen per day in office_____

9. Percent of patients- Medicare ____ Medicaid ____ Other _____

Practice Workflow Problems (Mark an X to all that apply):

☐ Chart chasing, lost charts	☐ Results tracking and follow up	☐ Difficulty staying on schedule
☐ Medication refills	☐ Poor legibility of medical records	☐ Patient waits to see physician/provider
☐ Phone/fax processing	☐ Expense of transcribing of notes, letters	☐ **Other- please specify**

Current Practice Management system:

10. **Does your practice currently utilize IT support?** ☐ **Yes** ☐ **No**
    If you answered yes – please provide name and telephone number of vendor.

11. What functionalities of your PM system are you using? (**Mark an X to** all that apply)

☐ Electronic Registration and Scheduling	☐ Web-based scheduling
☐ Electronic billing	☐ Other **Please list**

12. Does this software require connection to server? ☐ **Yes** ☐ **No**
    If yes, server location? ☐ **Off site** ☐ **On-site**

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EMR System: If you don't have an EMR system:

13. Have you budgeted for this purchase? ☐ Yes ☐ No
14. Have you explored any EMR systems? ☐ Yes ☐ No
15. **If you answered yes please specify**?

16. What do you feel your major needs for assistance will be in selecting and implementing an EMR? **Please place an X to 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
☐ **Other: _____**

If you currently have an EMR system:

17. What is the name of your system (including version)?
18. When was your system purchased? **Month**: **Year:**
19. When was your EMR system implemented? **Month:** **Year:**
20. What functionalities of your EMR system are you using? (**Mark an X to** all that apply)

☐ E-prescribing	☐ Problem List
☐ Lab results	☐ Patient education module
☐ Medication lists	☐ Coding support
☐ Patient notes/documentation	☐ E-superbills
☐ Disease management/health maintenance	☐ Internal messaging and task assignment tracking

Use of Data:

21. Do you participate in Physician Quality Reporting Initiative (PQRI) or other payor quality reporting programs?
☐ **Yes** ☐ **No**
22. If yes, which programs? (Governor's Chronic Care Initiative, NCQA Patient Centered Medical Home, etc.)

23. If yes, how is the data submitted for this program? ☐ Claims-based ☐ registry ☐ paper ☐ other: _____

24. Does your practice conduct internally driven patient care initiatives? ☐ Yes ☐ No

(Please identify initiatives)_____

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Use of Technology:					
High speed internet connection	☐ Yes	☐ No	Online patient form completion	☐ Yes	☐ No
Patient portal	☐ Yes	☐ No	Patient care registry	☐ Yes	☐ No
Electronic links with hospital/labs	☐ Yes	☐ No	Practice website	☐ Yes	☐ No
E-prescribing (Freestanding)	☐ Yes	☐ No	Online patient form completion	☐ Yes	☐ No
Email	☐ Yes	☐ No			
Voice recognition/Dictation	☐ Yes	☐ No			

Other Notes: Is there any other additional information/details you think would be helpful for us to know?

Next Steps: