



A Framework for Evaluating Electronic Health Records Overview - Applying to the Davies Ambulatory Awards Program Revised – May 2012

Introduction

The Computer-Based Record Institute (CPRI) established the Davies Recognition Program in 1994 to recognize exemplary implementations of electronic health records (EHR) and foster wider adoption by sharing lessons learned from those organizations. The first awards were granted in 1995. Management of the Davies Program continues under HIMSS, which merged with CPRI-HOST in 2002.

The program is named after Dr. Nicholas E. Davies, a practicing physician and President-elect of the American College of Physicians. Dr. Davies, a member of the Institute of Medicine Committee on Improving the Patient Record, died in an airplane crash in April 1991. He was a caring and accomplished physician who believed that computer-based patient records were needed to improve patient care.

The Davies Awards of Excellence is similar to the [Baldrige Award](#) in that it requires that staff in the healthcare system applying for the award to assess and document their progress and accomplishments against a framework for thinking about the process of implementing an EHR. This document provides the framework for conducting the self-assessment.

Who Can Apply?

The purpose of this award is to recognize the most exemplary implementations and utilizations of electronic health records in 1) **independent ambulatory practices**, 2) **community health clinics/organizations**, and 3) **enterprise clinics**. The Committee values personalization of the application. All submissions must come from the care delivery setting.

1. Independent Ambulatory Practices - Requirements to apply include the following:

- Applicants must be independently-owned (not hospital-owned) ambulatory practices (primary care and specialty medical practices). “Independent” means a practice that is not owned by an organizational (hospital) entity.
- Must have leveraged technology to impact patient-centric practice of medicine and derived value.
- Be willing to share approaches and lessons learned applicable to similar practices or organizations.



- See Appendix 1 for “Critical Qualifying Questions”. These are pre-requisites that must be met to be eligible to apply. These pre-requisites must be completed and submitted with the “Intent to Apply”.

2. **Enterprise Clinics** - Requirements to apply include the following:

Enterprise clinics can apply to the HIMSS Davies Ambulatory Award. Clinics that qualify are those that are owned or located within an academic medical center, IPAs, hospital systems.

- Independent urgent care centers and retail clinics do not qualify to apply.
- See Appendix 2 for “Critical Qualifying Questions”. These are pre-requisites that must be met to be eligible to apply. These pre-requisites must be completed and submitted with the “Intent to Apply”.

3. **Community Health Organizations** (CHO)- Requirements to apply include the following:

To qualify for the Davies CHO Award, the organization must:

- Provide primary medical care and preventive health services for the population served. The majority of the primary care is delivered directly, though some care, such as prenatal care and behavioral health, may be arranged via formal referrals.
- Maintain an open-door policy.
- Accept patients regardless of their ability to pay.
- See Appendix 3 for “Critical Qualifying Questions”. These are pre-requisites that must be met to be eligible to apply. These pre-requisites must be completed and submitted with the “Intent to Apply”.

Qualified Community Health Organizations include:

- Federally Qualified Health Centers (FQHC).
- FQHC look-alikes.
- School-based health centers that qualify under the PHS 330 program.
- County-run clinics.
- County hospital-based outpatient or free-standing clinics.
- Indian Health Service clinics (NOT hospitals).
- Family planning clinics (Planned Parenthood, Family PACT and Title X eligible).



- Rural health centers.
- Migrant health centers.
- Free clinics, and/or faith-based clinics.
- Healthcare for the homeless.
- Public health clinics.

Davies CHO Application Options:

1. **Option 1:** A single community health organization applies individually.
2. **Option 2:** One or two CHOs that participate with a collaborative entity apply with a description of how the collaborative entity supported each CHO in the EHR implementation and adoption process.
3. **Option 3:** Three or more qualifying CHOs that participate with a collaborative entity apply *in partnership* with the collaborative entity.

Application for the Davies Ambulatory Award is a 4-step process:

Step 1: Intent to Apply

Email your intent to apply to [Jonathan French](#), Director, Healthcare Information systems, HIMSS or call 703-562-8822 **60-days prior to submitting your case studies**. The intent to apply includes: 1) the name of your organization, 2) what facilities you plan to submit for the Davies Award application for consideration, 3) primary and secondary points of contact, 4) Pre-requisites table completed (see Appendix 1,2,3).

Step 2a: Core Case Study Applicants are required to complete the following two case studies [Table 1]: 1) a hard dollars Return on Investment (ROI) 5-page case study, to include status of participation in meaningful use, with one page Appendix (supportive metrics) (See Appendix #4), and 2) a clinical outcomes/value 5-page case study, with one page Appendix (supportive metrics) by the first business day of the month, following the 60-day notice of intent to apply.

Step 2b: Menu Case Study

Applicants are required to select two case study topics of their choosing among the following options listed in Table 2 below. Each case study cannot exceed 5-pages in length and can include an additional one page Appendix (supportive metrics). These two case studies are to be submitted at the same time as the two required case studies as described in Step 2 above.

Step 3: Site Visit

Based on independent review by the Davies Ambulatory Award Committee volunteer members, “Finalist” candidates are selected within 30 days after application submission. Finalists are those



who the Committee advances to a site visit after both independent scoring and Committee discussion and vote to a site visit. Those who are voted forward after the site visit will be recognized as “winners”.

Applicants will receive specific instructions for an in person site visit. The applicant will demonstrate their EHR system to a Davies Award Committee site visit team. Additionally, the applicant will arrange interviews with key people from management, information systems, clinical users and other departments.

Step 4: Submission of Final Case Studies to HIMSS Website and Educational Offerings

Davies Award winners may be asked to emphasize exemplary aspects of their approaches or accomplishments in the final submission of their case studies. Providers who apply and are accepted for consideration must accommodate a site visit (virtual or in person), comply with all deadlines for submittal of materials, sign a copyright agreement for inclusion of the application paper on the HIMSS website and HIMSS and educational offerings.

If you have questions, e-mail or call, Jonathan French, Director, Healthcare Information Systems, HIMSS, at davies@himss.org or 703-562-8822

Table 1

Hard ROI	Hard dollars and cents. If applicable, must include CMS EHR incentive program dollars (but not exclusively).
Soft ROI	Reduced liability, improved patient safety, increased satisfaction, decreased turn-around-times, etc.
Clinical value	Clinical outcomes
	The Joint Commission core measures
	CMS EHR incentive program core measures

Table 2: Case Study Topics – Select Two

- Usability
- End-user efficiency
- Leadership/Governance



- Population Management
- Medical device connectivity
- Innovation
- Change management – workflow analysis and improvement
- Health Information Exchange (HIE)
- Privacy & Security
- Mobile
- Dashboards and analytics: Clinical Informatics/Business Informatics
- Clinical care surveillance
- Telehealth
- Infrastructure innovations
- Patient safety enhancements
- Patient engagement
- Integrated specialty areas (oncology, anesthesia)
- Ancillary: (Radiology/imaging management; physician therapy; occupational therapy; robotics)
- Disaster planning and preparation / emergency operations center (EOC) effectiveness
- Patient flow/ throughput
- Syndromic Surveillance
- Laboratory Reporting
- Immunization
- Reduce hospital re-admissions within 30 days
- Reduce preventable hospital acquired conditions

Appendix 1 - “Critical Qualifying Questions”- Independent Ambulatory Practices

- Physicians and staff in a qualifying practice need to have incorporated the EHR into routine care to improve the operation of the practice and the management of the patient care processes.
- One hundred percent of providers and clinical staff must use the EHR to:
 1. Enter all patient encounters at the point of care and any patient requests for data, including phone messages, medication refill requests, forms, etc.



2. Generate prescriptions (ideally, the successful use of e-prescribing). Please indicate if your practice participates in e-prescribing incentive initiative offered by the Centers for Medicare and Medicaid Services (CMS), such as Medicare Improvements for Patients and Providers Act (MIPPA) or other payer-related incentive programs.
3. Where possible place electronic orders out and/or receive electronic results. (An example would be between the practice EHR and an outside laboratory.)
4. Using an EHR in a meaningful way should result in improvement in patient care—not just monitoring. A strong application will show both successful monitoring, as well as clear improvements in patient care that can be attributed to the use of the EHR. Show evidence of quality monitoring, which includes but are not limited to the following:
 - At the point of care, have a quality measurement system integrated into the EHR.
 - Produce quality reports within clinic or statewide or national measures, such as HPV vaccine administration.
 - Physician Quality Reporting Initiative (PQRI) participation and use of results is acceptable as evidence of quality monitoring, but responsiveness to this information resulting in improved patient care is essential.

As the Davies Award measures success in terms of the value achieved through EHR implementation, the practice also needs to have been using the system for all providers at all locations since at least **2** of the years previous to submitting the application. This is required to provide sufficient evidence of improvements in efficiency, quality, service and staff or patient satisfaction as appropriate to the local expectations that led to the investment in the first place.

Below are pre-requisites that must be met to be eligible to apply. These pre-requisites must be completed and submitted with the “Intent to Apply”.

		Yes (Y)	No (N)
1.	My practice has accomplished 100 percent usage of the EHR system at the point of care by all clinical staff, including providers, at least two year prior to application submission.		
3.	My practice has demonstrated improved outcomes in quality, safety, efficiency and/or reduced health disparities.		
4.	My practice's EHR is used to engage patients and families through the use of patient portals, text messaging, or other communication models or methods.		



5.	My practice's implementation of the EHR has demonstrated care coordination for patients across the care team.		
6.	My practice's implementation of the EHR ensures adequate privacy and security for protected health/personally identifiable health information.		
7.	Where possible, my practice utilizes digital e-prescribing (not fax) and the EHR to generate all appropriate prescriptions.		
8.	If available, my implementation of the EHR has functional interfaces that allow transmitting and/or receiving of results and orders.		
9.	My practice has an EHR business continuity plan, and has tested it for back-up, recovery and disaster recovery.		
10.	My practice can demonstrate workflow transformation through the use of the EHR, which is integrated with other health IT.		
11.	My practice's EHR implementation and usage is a model for other practices, and we have a provider champion who is willing to share our experience with others.		

Appendix 2 - “Critical Qualifying Questions”- Enterprise Clinics

These are pre-requisites that must be met to be eligible to apply. These pre-requisites must be completed and submitted with the “Intent to Apply”.

	Yes (Y)	No (N)
My practice has accomplished 100 percent usage of the EHR system at the point of care by all clinical staff, including providers, at least two year prior to application submission.		
My practice has demonstrated improved outcomes in quality, safety, efficiency and/or reduced health disparities.		
My practice's EHR is used to engage patients and families through the use of patient portals, text messaging, or other communication models or methods.		
My practice's implementation of the EHR has demonstrated care coordination for patients across the care team.		
My practice's implementation of the EHR ensures adequate privacy and security for protected health/personally identifiable health information.		



Where possible, my practice utilizes digital e-prescribing (not fax) and the EHR to generate all appropriate prescriptions.		
If available, my implementation of the EHR has functional interfaces that allow transmitting and/or receiving of results and orders.		
My practice has an EHR business continuity plan, and has tested it for back-up, recovery and disaster recovery.		
My practice can demonstrate workflow transformation through the use of the EHR, which is integrated with other health IT.		
My practice's EHR implementation and usage is a model for other practices, and we have a provider champion who is willing to share our experience with others.		

Appendix 3 - “Critical Qualifying Questions”- Community Health Organizations

I. The following information must be included with your “Intent to Apply”:

1. Are you applying as a group, collaborative or partnership? If so, please explain the group, collaborative or partnership.
2. Include a brief summary of the leadership support for the application.

II. These are pre-requisites that must be met to be eligible to apply. These pre-requisites must be completed and submitted with the “Intent to Apply”.

		Yes (Y)	No (N)
1.	100 percent of the core clinical providers and staff have adopted the EHR system and have been using it for at least two years prior to the due date of the Davies Award submission.		
2.	My CHO defined and achieved specific goals related to the EHR implementation and desired outcomes for our patients and our operation.		
3.	100 percent of the core clinical providers and staff at my CHO* use the EHR for all patient encounters at the point of care.		
4.	My CHO* has demonstrated improved outcomes in quality,		



	safety, efficiency and/or reduced health disparities, since implementation of the EHR, that meet or exceed state or national benchmarks.		
5.	My CHO's* EHR is being used to engage patients and families in the clinic and/or through the use of other communication methods.		
6.	My CHO's* implementation of the EHR facilitates care coordination for the patient across the care team.		
7.	Where possible, my CHO* utilizes digital e-prescribing (not fax) and the EHR to generate appropriate prescriptions.		
8.	My implementation of the EHR has functional interfaces that allow transmitting and receiving results and orders, if available.		
9.	My CHO* has an EHR business continuity plan, and has tested it for back-up recovery and disaster recovery.		
10.	My CHO* can demonstrate workflow transformation through the use of the EHR.		
11.	My CHO has demonstrated sharing of our experience with others and serves as a model for other CHOs.		
12.	My CHO is working toward meeting the goals and objectives of meaningful use, as outlined by CMS.		
13.	My CHO engages with partners outside our organization to improve care delivery and coordination through our EHR and health IT.		

*CHO = The entities being submitted for consideration

Please provide a “yes” or “no” response to the following questions. If, as a network collaborative entity, you answer “no” to any of the following questions, you may not be eligible to apply.

<i>Does your network work with member CHOs to perform clinical and operational functions such as:</i>	Yes	No
<i>1. Analysis of performance data and identification of corrective action.</i>		
<i>2. Designing clinical protocols.</i>		
<i>3. Designing and delivering clinical staff training.</i>		
<i>4. Analysis and design of clinical workflows for improved efficiency.</i>		
<i>5. Designing and implementing other management and clinical</i>		



processes.		
6. Assessment of results reflected in reporting tools, such as dashboards and recommendations for improvements.		
7. Sharing of successful tools, improvement processes and management/clinical decision making throughout the network.		
8. Developing common reports for use among the CHOs.		
9. Benchmarking CHOs with each other.		



---APPENDIX #4---

Since it may have been some time since the implementation of the EHR and this may make determining the ROI difficult, we have provided a table that you may use. Feel free to make adjustments as appropriate for your organization. This is one example of a way to determine the ROI.

INVESTMENT

I. EHR SOFTWARE

a. EHR software (licenses for providers, users and enterprise).	
b. EHR-related software (scanning, voice recognition, report writer, etc.)	
c. EHR software billed yearly (e-prescribing, CPT/ICD, medical necessity, etc.)	
d. Interfaces (labs, PM system, devices, hospitals, etc.)	
e. Yearly EHR and EHR-related software maintenance/support.	

II. HARDWARE

a. Local servers (for EHR, images, etc.)	
b. EHR user devices (PCs, tablets, laptops, scanners, upgrades to existing PCs, etc.)	
c. Networking equipment (racks, switches, wireless, cabling, UPS, generator, etc.)	
d. External connectivity (internet, T1 lines, etc.)	
e. External services (hosting, disaster recovery, data center, etc.)	



III. ADDITIONAL COSTS

a. Training costs for EHR and EHR-related software (I.A. and I.B.)	
b. Ancillary costs related to training (travel, temporary classrooms, etc.)	
c. Technical support.	
d. Server software (SQL, Windows, backup software, faxing software, etc.)	
e. Additional personnel costs directly related to the EHR	
f. One time implementation costs (scanning, temporary services, etc.)	

RETURNS

I. PAPER CHART COST SAVINGS

a. Reduction in Transcription costs.	
b. Malpractice reductions.	
c. Reduction in paper chart supplies.	
d. Reduced need for paper chart space and storage.	

II. STAFFING SAVINGS

a. Reduction in overtime hours paid.	
b. Reduction in staff-to-provider ratio.	
c. Reduction in billing costs.	

III. INCREASED COLLECTIONS

a. Increased collections for providers.	
b. Increased procedure charges.	
c. PQRI incentives.	
d. Grants or other pay-for-performance monies.	
e. Change in level of service billing before and after implementation.	
f. Reduction in A/R relative to monthly billings.	

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