



A Framework for Evaluating Electronic Health Records

Guidelines for Applying to the Davies Recognition Program Organizational Healthcare Threshold Application

Revised - January 2010

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1. Submitting the Threshold Application

The Threshold Application for the Davies Award Program is a document that summarizes the electronic health record (EHR) of an organization and should not exceed nine (9) pages, plus a cover page and the appendices. Note that “organization” means an enterprise or business organization which may include multiple organizations, facilities and care settings.

The organization name, page number and date should be on the footer of each page. The font should be 12-point Times New Roman, with one-inch margins. Below is a description of each page and required forms:

On the cover page provide the organization’s name, address, a primary point of contact, an alternative point of contact and the year of submission.

Applicants with questions are encouraged to e-mail or call David Collins, HIMSS Director, Healthcare Information Systems, at dcollins@himss.org at 804-550-1619. E-mail the Threshold Application as a PDF to David Collins by **5 p.m. (ET) on March 31**.

Applicants are urged to submit the Threshold Application as soon as possible. Feedback from the Davies Committee will be communicated within one month of your submission. Earlier submissions allow eligible applicants more time to complete the Full Application.

NOTE: *Completion of the Threshold Application is mandatory to be considered for the Nicholas E. Davies Award. Only healthcare provider organizations may apply for Davies recognition. While vendors and consultants cannot be the official respondent, they are encouraged to assist their clients. The provider organization is the applicant and the award winner.*

2. Description of Organization and EHR Project (Page 1)

On page one, provide a summary of the organization (1/2 page). Describe the corporate structure and list the facilities. Complete the Facilities Table (Appendix 1). Indicate which facilities or parts of the organization are being submitted for the Davies Award. For example, if the organization has an integrated delivery network with multiple hospitals, clinics, physician practices or long-term care facilities, indicate whether the organization is applying for the entire network or for one or more of the facilities. Note that the Self-Evaluation Forms should clearly describe those areas of the organization which have been implemented. Summarize the rationale behind the EHR implementation, and include the major reasons, drivers and leadership that led to the decision to embark on the journey toward an EHR.

Describe the **EHR Project** by answering the following questions (1/2 page):

- What were the organization’s strategic objectives, and how is the EHR project integral to achieving those objectives?
- How were the business/clinical goals set, and who was involved in setting these goals?
- How was achievement of the goals to be measured?
- Who was involved in implementing and monitoring achievement of these goals?
- How was the project organized? (Include the role of the Board, executive leadership, physicians, Information Services and end users.)
- How was the project funded?

3. EHR Applications Implemented (Page 2)

On page two, include a summary of the EHR applications implemented. Prepare an Applications Table (**Appendix 2**) for the applicant's organization. Provide an overview of the applications and implementation phases. Describe the level of integration, or lack thereof, and plans for additional integration or applications. Include plans for non-implemented areas to help paint a complete picture of the organization. Discuss any plan to exchange data with external organizations, including health information exchanges (HIE).

4. Narrative Description of Information Flow (Page 3)

An Information Flow Graphic should be included as **Appendix 3**, to show from a functional perspective how the EHR acquires, stores, transmits and retrieves data, information and knowledge from multiple sources from one facility to the next, including patient flow from ambulatory to emergency department to acute care and how data is made available to/from ancillary departments and other settings of care.

On page three, describe the information flow and include how a patient is identified and what data/documents are available within the same user interface to the provider for the diagnosis and treatment of the patient. Indicate any exceptions which require the provider to sign on or switch to another information system. Identify any differences by facility, if applicable.

5. Process Automation (Page 4)

On page four, list and describe the five most important work/care processes that were redesigned and automated through the use of the EHR. Identify the major system functions that support these work processes.

6. Clinical Decision Support, Usage and Outcomes (Page 5)

Page five should describe the tools that provide added value in supporting clinical decisions (clinical decision support, or CDS). Complete the Clinical Decision Support Table as **Appendix 4**. Summarize the real-time decision support (rules, prompts and reminders) that physicians and other caregivers are using. For each CDS tool identified in the table, describe how the CDS tool is used by the care providers, how care processes changed and if there is any outcome measure to indicate its effect per the following questions:

- How has the EHR transformed care processes and outcomes?
- How does the system guide and inform standard practices and promote evidence-based care? (Provide examples)
- From where does the organization derive best practices? (i.e., local practice, evidence-based literature, commercial sources, etc.)
- How has the organization impacted patient safety and quality of care with the EHR system? (Include specific measures for those impacts.)
- Do you monitor rate of alerting? Rate of alert overrides? Management of CDS system based on effectiveness of CDS?

7. System Capabilities for Analysis and Reporting (Page 6)

On page six, describe the system's capabilities for analysis and reporting. Describe how the system design provides for the capture and storage of interpretable and consistent data that is used to discover improvement opportunities in care delivery, effectiveness, efficiency, quality and/or safety. Describe which types of data are available in the EHR as discrete data elements that the organization is able to report against.

8. User Satisfaction (Page 7)

On page seven, describe how end-users view the system and how satisfied they are in utilizing the system to view patient records and document care. Describe and include the following:

- How does the organization measure physician and other caregiver satisfaction with the EHR?
- What survey tools are used to measure physician and other caregiver satisfaction-level statistics?
- How often users—and what types of users—are surveyed?
- What methods are used to assure continuous quality improvement based on feedback from users and providers?

9. Value/Quantifiable Benefits (Page 8)

On page eight, describe the value/quantifiable benefits the organization has achieved through its use of the EHR. Provide quantifiable, measurable results of value (include financial, clinical, regulatory, research, public health, advocacy or other examples). Relate these measurable results to the goals set at the beginning of the project, where applicable. These could include return-on-investment analyses, quality improvement metrics and achievement of organizational objectives. Describe other qualitative improvements achieved through the use of the EHR.

10. Meaningful Use (Page 9)

Proposed definitions from CMS for meaningful use can be found at the [Meaningful Use Matrix](http://www.federalregister.gov/OFRUpload/OFRData/2009-31217_PI.pdf) at the following URL: http://www.federalregister.gov/OFRUpload/OFRData/2009-31217_PI.pdf. For organizational settings, this document proposes what will be needed to achieve the goal of safe, efficient and effective care that will enable patients and providers to achieve optimal outcomes. It is important that your application speaks to the achievement of meaningful use within your organization subsequent to the implementation of the EHR. Some of the meaningful use criteria may not apply to behavioral health organizations. On page nine, describe what your organization is doing in conjunction with your EHR vendor to substantially address the proposed Meaningful Use criteria. Visit [HIMSS Web site](http://www.himss.org/EconomicStimulus/) at <http://www.himss.org/EconomicStimulus/> for up-to-date analysis and information regarding ARRA. Please utilize the HIMSS tool that enables hospitals to track their compliance with Stage 1 Meaningful Use criteria requirements by process group. The tool provides the user with progress score sheets and graphical representations by the year and project life cycle at www.himss.org/ASP/topics_FocusDynamic.asp?faid=330. Please provide a summary of percentage progress to date for the hospital entities for which you are applying.

11. EHR Implementation Self-Evaluation Form

For each type of care setting in each of the facilities for which you are submitting this application, complete the Self-Evaluation Form (**Appendix 5**). The form is provided for

organizations to evaluate the extent of their implementations and the pervasiveness of EHR use by care providers and staff in the delivery of care.

12. Qualifying Questions

Include in **Appendix 6** applicant responses to the tables Critical Qualifying Questions and Other Qualifying questions.

Appendix 1: Facilities Table

Prepare a table of all the entities in the organization, similar to the example below from 2007 Davies Organizational Award-winner Allina Hospitals & Clinics (e.g., hospitals, home-care agencies, long-term care facilities, physician offices, behavioral health sites). Include with an asterisk which facilities are **not** included in the application. Note: Do not exclude a single entity within your organization, such as an intensive care unit within a hospital. For each organization/facility, provide the following:

- Facility name, location(s) and major services/care settings provided by that facility (e.g., inpatient, cancer center, emergency department operating room, ambulatory care, rehabilitation services).
- Operating revenue and expenses.
- Total number of employees.
- Number of physicians (staff and non-staff) and nurses.
- Key statistics. For example, admissions, census, visits, patient days, beds, tests, prescriptions or surgeries.

	Entity	Figures		Types of Service
Metro Hospitals	Abbott Northwestern Hospital Minneapolis, MN.	\$696,175M net revenue; 5,200 employees; 1,649 physicians.	38,511 inpatient admissions; 245,017 outpatient admissions; 621 beds.	Complete medical, surgical and critical care for patients from age 12 to older adults; 24-hour emergency services; multi-specialty care and clinical expertise in behavioral health, cardiovascular services, medical/surgical services, neuroscience, oncology, orthopedics, rehabilitation, spine care and women's health; outpatient care in more than 50 different specialty areas.
	Mercy &Unity Hospitals Coon Rapids and Fridley, MN.	3,700+ employees and 842 physicians.	Emergency services; Bariatric and weight loss center; behavioral health; breast care program; women's and children's services cancer center; cardiac centers; diagnostic imaging; rehab services; orthopedic and neuroscience.	

Metro Hospitals	Mercy \$267,387M net revenue; 19,302 inpatient admissions; 95,599 outpatient admissions; 271 beds.	Unity \$157,911M net revenue; 12,769 inpatient admissions; 68,741 outpatient admissions; 275 beds.		
	Phillips Eye Institute Minneapolis, MN.	\$26,397M net revenue; 168 employees; 179 physicians.	15,861 outpatient admissions; 453 inpatient admissions; 20 beds.	Diagnosis and treatment of eye problems; inpatient care; eye care for children; LASIK surgery and vision rehabilitation.
	United Hospital St. Paul, MN.	\$382,792M net revenue; 3,300 employees; 1,400 physicians.	27,402 inpatient admissions; 99,394 outpatient admissions; 553 beds.	Bariatric surgery; birth center; cancer care; day surgery; emergency services; integrative therapies; heart hospital, neuroscience center; radiology; menopause center; psychiatry and behavioral health; rehab, eye surgery center; accident and injury clinic; and vascular center.
	Buffalo Hospital Buffalo, MN.	\$40,395M net revenue; 415 employees; 180+ physicians.	2,715 inpatient admissions; 37,820 outpatient admissions; 65 beds.	Emergency services; intensive coronary care; oncology and urgent care; specialty services, including birth center, cardiac center, sleep center and the Sister Kenny Rehabilitation Institute.
	Cambridge Medical Center Cambridge, WI.	\$105,360M net revenue; 1,130+ employees; 50+ providers.	3,648 inpatient admissions; 121,355 outpatient admissions; 88 beds.	Clinic services; behavioral health; eye care; emergency services; eye care; breast feeding clinic; radiology; surgery; therapy and rehab services; and respiratory care.

Metro Hospitals	New Ulm Medical Center New Ulm, MN.	\$51,406M net revenue; 504 employees; 40 physicians.	2,387 inpatient admissions; 68,609 outpatient encounters; 48 beds.	Emergency services; renal dialysis; respiratory therapy; chemotherapy; birth center; surgery center; mental health; and substance abuse.
	River Falls Area Hospital River Falls, WI.	\$26,123M net revenue; 210 employees; 156 physicians.	1,612 inpatient admissions; 15,491 outpatient admissions; 25 beds.	Diagnostic services; emergency services; heart care; homecare and hospice; birth center; sleep center; and sports medicine rehabilitation and wellness center.
	St Francis Regional Medical Center Shakopee, WI.	\$86,653M net revenue; 740 employees; 400 physicians.	5,615 inpatient admissions; 80,208 outpatient admissions; 70 beds.	Emergency services; birth center; cancer center; hospice and palliative care; rehab and sports medicine; and diagnostic services.
	Owatonna Hospital Owatonna, MN.	\$37,328M net revenue; 325 employees; 52 physicians.	2,664 inpatient admissions; 32,038 outpatient visits; 48 beds.	Birth center; center for rehab and wellness; chemical health program; emergency and urgent care; hospice; home and palliative care; mental health services; sleep center; and surgery center.
	Allina Medical Clinics (AMC) 65 locations in MI and WI.	\$275,476M net revenue 369 physicians 3,786 employees.	1,913,601 outpatient visits.	Acupuncture; allergy; audiology; cardiology; chiropractic; ENT; family practice; surgery; gynecology; infectious disease; internal medicine; radiology; obstetrics; occupational medicine; oncology; optometry; orthopedics; physical therapy; plastic surgery; travel clinic; ultrasound; urology; and vascular services.

Appendix 2: Applications Implemented Table

Prepare a table which lists the major applications which have been implemented within the organization, similar to the example provided below from 2008 Davies Organizational Award-winner Eastern Maine Medical Center. Include the following information:

- Functionality, major vendor(s) and major application capabilities implemented (e.g., order management, CPOE, CDS, clinical documentation, patient registration, appointment scheduling, billing, laboratory, pharmacy, medication administration or closed loop medication administration, surgery, intensive care, emergency department, cardiology, radiology, PACS, etc.).
- Indicate if application is fully integrated, partially integrated, standalone.
- For the entities for which the organization is submitting this application, list the date of the initial EHR implementation; or status of deployment, if in process or planned.

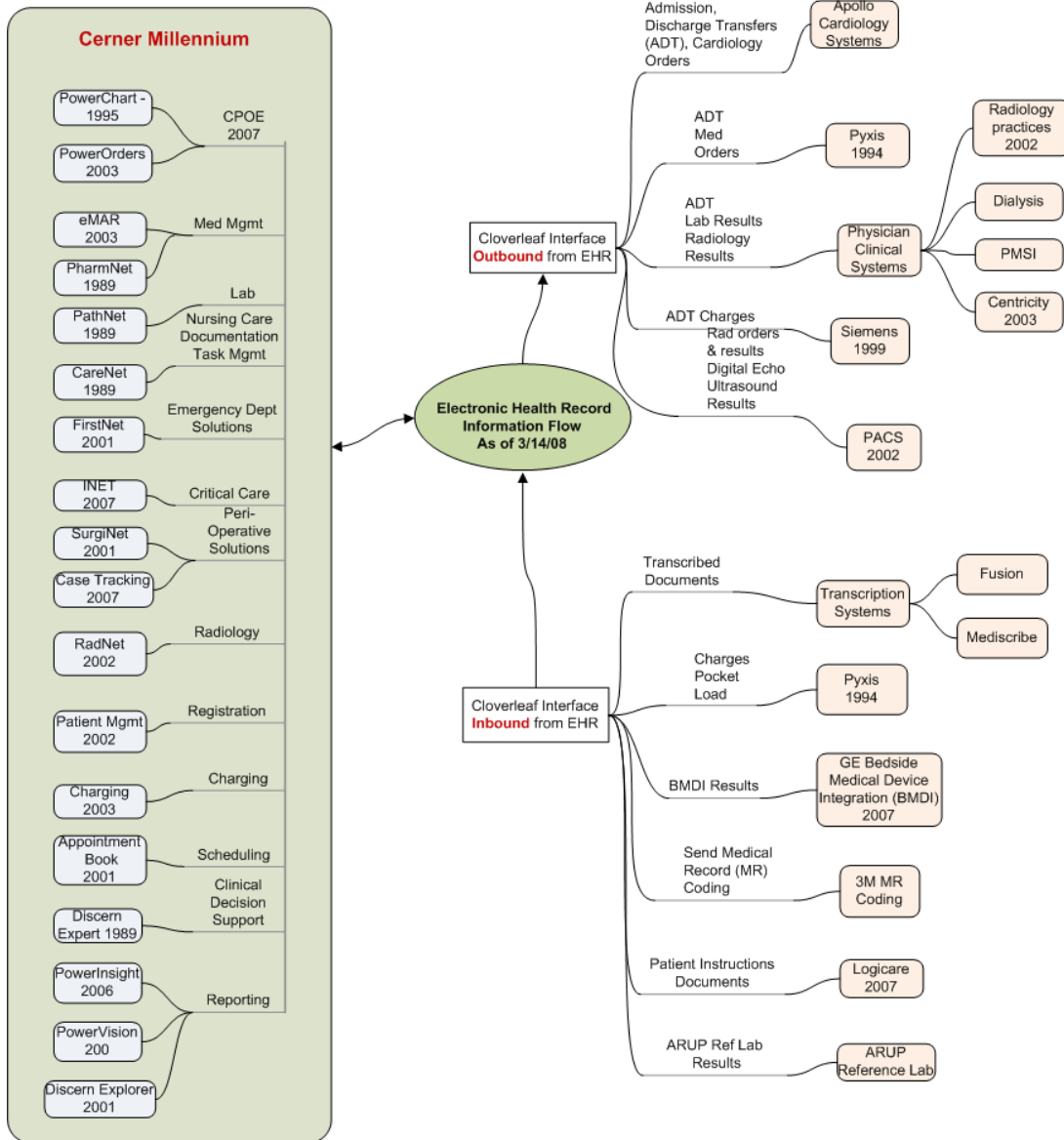
Application (Date of Initial Implementation)	Functionality	Sites			
		TG	AH	MB	Clinics
Cadence Ambulatory (Feb. 1998)	Full scheduling capabilities for ambulatory clinics.				✓
Cadence Hospital (June 2007)	Full scheduling capabilities for inpatient.	✓	✓	✓	
Clarity (Aug. 1999)	Ability to access reports developed by the project's Clarity Reporting Team.	✓	✓	✓	✓
EpicCare Ambulatory (Aug. 1998)	Clinical documentation tools, including notes and templates, vital signs entry, and all form of documentation.				✓
ASAP (June 2007)	Status board, documentation tools and order sets.	✓	✓	✓	
EpicCare Inpatient (June 2007-Oct. 2008)	CPOE; nursing documentation and workflow support; Medication Administration Record (MAR); interdisciplinary clinical notes; patient education; and charge on administration.	✓	✓	✓	
EpicCare Rx (June 2007)	All pharmacy functions, including pharmacy work list, Pyxis integration, medication charging, allergy and drug alerting, and medication database.	✓	✓	✓	
OpTime (Jan. 2009)	Surgery application . status boards, OR/PACU documentation, room utilization, charging and materials management.	✓	✓	✓	
Beacon (Dec. 2007)	Oncology application including treatment plans based on standard protocols, treatment decisions and personalized plans for both adults and pediatric patients.	✓	✓	✓	

Radiant (TBD)	Radiology application including radiology worklist, exam statusing and integration with PACS and CVIS.	□	□		□
Prelude ADT (June 2007)	Hospital registration and admission, discharge, transfer (ADT) application	✓	✓	✓	
Prelude Ambulatory (Feb. 1998)	Clinic registration application.				✓
Resolute Professional Billing (Feb. 1998)	Billing, claims, collections and A/R management for hospital fees.	✓	✓	✓	✓
Resolute Hospital Billing (June 2007)	Billing, claims, collections and A/R management for hospital fees.	✓	✓	✓	✓
EpicCare Home Health (Oct. 2004)	Documentation and charting tools that help coordinate patient care and improve communications with physicians and handle case assignments for home care providers.	✓	✓	✓	✓
Health Information Management (HIM)/ Chart Tracking (June 2007)	Chart and file management and tracking, release of information, coding and deficiency tracking.	✓	✓	✓	✓
Nurse Triage (April 2002)	Creates appropriate care documentation automatically, generating context-specific alerts and offering convenient access to scheduling information for nursing.	✓	✓	✓	
Identity EMPI (Nov. 2002)	Merges records when duplicates are found and unmerges patient records when necessary.	✓	✓	✓	✓
Tapestry (Feb 1998)	Manage authorizations, compares capitation receipts against eligibility history, and reconciles claim payments against contracts.				✓
MyChart (April 2004)	Patient portal allowing patients online access to portions of their medical record, such as labs, medications and appointment scheduling.	✓	✓	✓	✓
EpicWeb (Nov. 1999)	Web portal to EHR and scheduling.	✓	✓	✓	✓

In Process	□
Implemented	✓

Appendix 3: Representative Information Flow Graphic (modeled after 2008 Davies Award winner, Eastern Maine Medical Center)

Produce a graphic diagram for your organization, including major applications, dates of implementation, interfaces and major settings of care. An example of such a diagram follows:



Appendix 4: Clinical Decision Support Table

In this table, describe the EHR tools that provide added value in supporting clinical decisions in each location. An example of such a table follows:

<u>Location</u>	<u>CDS</u>	<u>Physicians</u>	<u>Nursing</u>	<u>Pharmacy</u>
Inpatient	Dose Range Checking (Y/N)			
	Drug-Drug (Y/N)			
	Drug-Allergy (Y/N)			
	Drug-Food (Y/N)			
	Drug-Laboratory (Y/N)			
	Links to Resources (Y/N)			
	Best-Practice Alerts (Y/N)			
	Regulatory Compliance (Y/N)			
Outpatient	Dose Range Checking (Y/N)			
	Drug-Drug (Y/N)			
	Drug-Allergy (Y/N)			
	Drug-Food (Y/N)			
	Drug-Laboratory (Y/N)			
	Links to Resources (Y/N)			
	Best-Practice Alerts (Y/N)			
	Regulatory Compliance (Y/N)			
ED	Dose Range Checking (Y/N)			
	Drug-Drug (Y/N)			
	Drug-Allergy (Y/N)			
	Drug-Food (Y/N)			
	Drug-Laboratory (Y/N)			
	Links to Resources (Y/N)			
	Best-Practice Alerts (Y/N)			
	Regulatory Compliance (Y/N)			
Other Sites (If Multi Facility)	Dose Range Checking (Y/N)			
	Drug-Drug (Y/N)			
	Drug-Allergy (Y/N)			
	Drug-Food (Y/N)			
	Drug-Laboratory (Y/N)			
	Links to Resources (Y/N)			
	Best-Practice Alerts (Y/N)			
	Regulatory Compliance (Y/N)			

Appendix 5: Self-Evaluation Forms

Complete a separate self evaluation for your organizations and major types of care facilities applied for in this application (e.g., inpatient, cancer care, emergency department, operating rooms, anesthesiology, ambulatory clinics, physician offices, long-term care, home care, etc.) Care facilities can be aggregated where use and proportions are similar. Add more columns for locations or rows for types of EHR users where appropriate (e.g., case managers, triage nurses, community health nurses, clinical psychologists.) Tally users who work across locations in their primary location. The percentage of users should be the percentage of users of that type, i.e., percentage of physicians. If completing this for multiple facilities, please aggregate data for all facilities expressed as mean percentage (range) in each major care setting as noted above. The term Licensed Independent Practitioner (LIP) is defined by The Joint Commission (2005) as: *“Any practitioner permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the practitioner license and consistent with individually assigned clinical responsibilities”*.

Type of Care Facility: _____

Location(s) _____

1. How prevalent is use of the EHR?

	# of possible EHR users at these locations	% of users of EHR at these locations
Physicians		
Nurse Practitioners/Physician Assistants		
Nursing		
Ancillary/Other		

2. Provide the percentage of providers* using **CPOE** in these care settings.

Location	# of Possible CPOE Users	% Using CPOE	% of Orders Entered by Provider		
			Medication	Electronic	
Inpatient LIPs				Verbal/Telephone	
				Written	
				Protocol	
				TOTAL	0%
			Non Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
				TOTAL	0%



Location	# of Possible CPOE Users	% Using CPOE	% of Orders Entered by Provider		
Inpatient Staff who are not LIPs			Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
			TOTAL	0%	
			Non Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
			TOTAL	0%	
TOTAL 0%					
<u>Location</u>	<u># of Possible CPOE Users</u>	<u>% Using CPOE</u>	<u>% of Orders Entered by Provider</u>		
Outpatient LIPs			Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
			TOTAL	0%	
			Non Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
			TOTAL	0%	
Outpatient Staff who are not LIPs			Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
			TOTAL	0%	
			Non Medication	Electronic	
				Verbal/Telephone	
			Written		



Location	# of Possible CPOE Users	% Using CPOE	% of Orders Entered by Provider		
				Protocol	
TOTAL					0%
<u>Location</u>	<u># of Possible CPOE Users</u>	<u>% Using CPOE</u>	<u>% of Orders Entered by Provider</u>		
ED LIPs			Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
			TOTAL	0%	
			Non Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
			TOTAL	0%	
ED Staff who are not LIPs			Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
			TOTAL	0%	
			Non Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
			TOTAL	0%	
TOTAL					0%
Other Sites (If Multi Facility) LIPs			Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
			TOTAL	0%	
			Non Medication	Electronic	



Location	# of Possible CPOE Users	% Using CPOE	% of Orders Entered by Provider		
				Verbal/Telephone	
				Written	
				Protocol	
				TOTAL	0%
Other Sites			Medication		
(If Multi Facility)				Electronic	
Staff who are not LIPs				Verbal/Telephone	
				Written	
				Protocol	
				TOTAL	0%
			Non Medication	Electronic	
				Verbal/Telephone	
				Written	
				Protocol	
				TOTAL	0%

Please describe any areas throughout the organization in which CPOE is not being used.

3. What form does clinical documentation take in this care setting? Enter percentages based on the total number of documents entered.

Location	Care Setting	% Paper Documents	% Scanned Document	% Text Documents (e.g. dictated, transcribed, or entered)	% Template Level (discrete field capture of clinical information)
Inpatient (Should total across to 100%)	Physicians				
	Nursing				
	Allied Health				
	Labs				
	Pharmacy				
	Radiology				



		% Paper Documents	% Scanned Document	% Text Documents (e.g. dictated, transcribed, or entered)	% Template Level (discrete field capture of clinical information)
Outpatient (Should total across to 100%)	Physicians				
	Nursing				
	Allied Health				
	Labs				
	Pharmacy				
	Radiology				
		% Paper Documents	% Scanned Document	% Text Documents (e.g. dictated, transcribed, or entered)	% Template Level (discrete field capture of clinical information)
ED (Should total across to 100%)	Physicians				
	Nursing				
	Allied Health				
	Labs				
	Pharmacy				
	Radiology				
		% Paper Documents	% Scanned Document	% Text Documents (e.g. dictated, transcribed, or entered)	% Template Level (discrete field capture of clinical information)
Other Sites (If Multi Facility) (Should total across to 100%)	Physicians				
	Nursing				
	Allied Health				
	Labs				
	Pharmacy				
	Radiology				
		% Paper Documents	% Scanned Document	% Text Documents (e.g. dictated, transcribed, or entered)	% Template Level (discrete field capture of clinical information)

4. Do all clinicians use the EHR as the primary tool for retrieving, documenting and communicating with others on the care of their patients? Yes/No. Describe any exceptions.



5. In 2005, HIMSS Analytics launched the [EMR Adoption ModelSM](#) (EMRAM) to track EMR adoption progress at hospitals and health systems. The EMRAM scores hospitals in the HIMSS AnalyticsTM Database on their progress in completing eight stages (0-7).

- Describe the major areas of functionality of your system in relation to this model.
- If you participate with HIMSS Analytics, please provide your EMRAM score.

6. Please be more specific about how the EHR is used in this setting. Which of these descriptions of EHR use is most accurate for this care setting? _____ (select one A - E and describe your selection at the end of this section)

- A. The EHR is the only source of care information (i.e., a paper chart is never created). Any paper information (signed consents, information from other health care providers, etc.) is scanned during the patient visit/admission to immediately become a part of the EHR. Describe what type of information is scanned into the EHR and how clinicians view the information once it is scanned.
- B. A partial paper record is created during the patient visit. The partial paper record is used in conjunction with the EHR. The partial paper record is scanned after the visit to become a part of the EHR. Describe what type of information is in the partial paper record.
- C. A partial paper record is created during the patient visit. The partial paper record is used in conjunction with the EHR. The partial paper record is filed and maintained on paper after the visit. Describe what type of information is in the partial paper record.
- D. A full paper record is created during the patient visit. The paper record is used in conjunction with the EHR. The paper record is scanned after the visit to become a part of the EHR. Describe how the EHR is utilized. Is the EHR used for historical records only? Is the EHR used as a redundant source of information?
- E. A full paper record is created during the patient visit. The paper record is used in conjunction with the EHR. The paper record is filed and maintained on paper after the visit. Describe how the EHR is utilized. Historical records? Redundant source of information?

Appendix 6: Qualifying Question Tables

Please answer yes or no to the following Critical Qualifying Questions. Some of these qualifying questions may not apply to behavioral health organizations; if so, indicate as such in the “Yes/No” box.

Critical Qualifying Questions	Yes/No	Brief Explanation (if needed)
1. Are there outcomes and value achieved by your organization directly attributable to your EHR implementation?		
2. Are more than 80 percent of all patient care orders entered into the EHR in advance of the execution of that order in all organizational locations for which you are applying?		
3. Are more than 80 percent of Licensed Independent Practitioners using CPOE to enter orders in all organizational locations for which you are applying?		
4. If your application is for multiple facilities, can a patient move between care venues (inpatient, outpatient, OR, ED, hospital to clinic, hospital to hospital) seamlessly using the same patient identifier?		
5. If your application is applying for multiple facilities, does your organization have an enterprise-wide Master Patient Index that shares a common database among all facilities that provides for a consistent and efficient view of individual patient information?		
6. Can a patient move between care venues seamlessly with the use of a single clinical data repository (i.e., with a common med list, allergy list, problem list)?		
7. Has your organization noted improved quality outcomes as a result of clinical decision support incorporation into the EHR?		
8. Can your organization describe in detail how you will meet CMS-defined meaningful use criteria? If your organization is selected for a site visit, you will be expected to have met meaningful use criteria.		



Additional Qualifying Questions	Yes/No	Brief Explanation (if needed)
1. Has the organization measurably reduced mortality, CA-BSI rates, VAP rates, medication errors, transfusion rates or any other safety metric as a result of your EHR implementation?		
2. Has the organization measurably improved turn around time for medications, radiologic studies or any other efficiency metric as a result of your EHR implementation?		
3. Has the organization measurably improved clinician efficiency as a result of your EHR implementation?		
4. Has the organization reduced inpatient length of stay as a result of your EHR implementation?		
5. Has the organization achieved measurable consistency in care delivery for conditions and/or procedures as a result of the implementation of electronic order sets, care plans or care pathways?		
6. Has the organization improved measured clinician or patient satisfaction scores as a result of the implementation of the EHR?		
7. Has the organization measurably demonstrated a financial return on investment as a result of the implementation of the EHR?		
8. Have the data derived from your EHR implementation resulted in the recognition of opportunities for improvement leading to performance improvement efforts?		
9. What percent of verbal orders are cosigned within 24 hours?		
10. Has the organization implemented closed loop medication administration (bar coding)?		