Stage 7 FAQs Compiled by MEDITECH

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The Stage 7 FAQs outlined below are garnered through information customers have received via email communication with HIMSS Analytics and direct communication between MEDITECH and HIMSS Analytics.

General Questions

Clinical Documentation

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CPOE

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General Questions

1) What expenses does the hospital incur for the EMRAM Stage 7 site visit?

Effective January 1, 2019, HIMSS Analytics will begin charging a flat $12,500 travel honorarium to cover the costs of the site visit. Historically, HIMSS Analytics budgeted approximately $25,000 a year for Stage 7 visits and once it was spent, they were finished with visits for the year. Charging for the visit enables HIMSS Analytics to keep up with increased demand and hospitals desire not to wait for site visits. [1]

The survey team consists of a senior HIMSS Analytics representative, CIO, and CMIO or CNIO. The surveyors are volunteers. They attempt to bring a physician and/or nurse using the same vendor system to the visit but it is not always feasible. For example, with a site visit to a pediatric facility, they believe it is important to have a physician from another pediatric facility and that takes precedence over the same vendor system. [2]

Effective January 1, 2018, HIMSS Analytics Europe is charging European organizations 5000 EUR for a Stage 6 validation visit and 9900 EUR for a Stage 7 validation visit.[3] Please contact HIMSS Analytics as these costs are subject to change.

2) Does HIMSS Analytics have a Frequently Asked Questions (FAQ) document?

No. HIMSS Analytics does not maintain an FAQ document. They will provide any hospital (client) with the 38-page Acute Care EMRAM Stage 7 Preparatory Guide that they use during the site visit. It is fine with HIMSS Analytics if a client shares the document with vendor(s).

Please see our MEDITECH Stage 6 & 7 resources available on our Stage 6 & 7 Checklists & Workflow Documents page.

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[1] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on April 4, 2014. Updated after discussion with Philip Bradley, Regional Director HIMSS Analytics, and MEDITECH on December 7, 2018.

[2] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics to MEDITECH on October 1, 2012

[3] Clarification provided by John Rayner, Regional Director HIMSS Analytics - HIMSS Europe, to MEDITECH on January 26, 2018

3) Will you share best practices?

HIMSS Analytics does not maintain any best practice documents. In response to asking for examples of best practice rules for Clinical Decision Support Systems (CDSS) in physician documentation, HIMSS cited VTE, CHF, and MI on the problem list. For VTE, there is a risk assessment of throwing a blood clot that goes through rule logic. For a surgical patient, there is a risk profile. It should define which patient population is high risk and come back with a suggested list of orders and interventions. If the patient is low risk for VTE, the system will return a different list of suggestions for the physician to consider. HIMSS wants to see both high and low risk support. Other typical examples include if MI is on the problem list and no aspirin is ordered, suggest the doctor to order. The CDSS should generate a disease/risk score and/or utilize a rule to require/suppress queries. Another example is the final diagnosis drives discharge medications. A behavioral health MEDITECH Stage 7 hospital provided psych services based on the patient's suicidal risk profiles which HIMSS mentioned was a good example.[4] Please see our Clinical Decision Support in Physician Documentation resources found on our Stage 6 & 7 Checklists & Workflow Documents page.

4) Do Stage 6 hospitals revalidate every year?

Currently, there is no requirement to revalidate for Stage 6 hospitals. HIMSS Analytics does have plans to introduce a Stage 6 revalidation process within the next few years. Stage 7 hospitals are required to revalidate every three years to retain their status.

5) How much notice does HIMSS Analytics require before scheduling a Stage 7 visit?

After the Stage 6 validation call occurs, HIMSS Analytics needs at least 3-4 months notice to schedule a Stage 7 validation visit. Note that HIMSS will not schedule visits in the weeks leading up to their United States annual conference held in the February/March timeframe. [5]

6) We are a multi-facility organization. How do you handle the site visits for our facilities?

If your facilities share a single EMR, HIMSS Analytics will go to one hospital and review organizational processes. The CIO completes an attestation form that the shared EMR software and protocols are identical and the clinical processes are the same at all hospitals. The one site visit will serve as validation for all hospital facilities.[6]

HIMSS Analytics confirmed that key clinical processes, i.e. pharmacy orders/verified, CPOE rates, BMV/TAR/human milk scanning, need to be the same between the facility that hosted the visit and the facilities noted on the attestation form.[7]

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[4] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 1, 2012

[5] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to Inland Northwest on October 29, 2012

[6] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to Inland Northwest on October 29, 2012

[7] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to Centura Health on December 19, 2012

7) Do stand-alone rehabilitation hospitals (no acute services) qualify for EMRAM Stage 6 or 7? I would appreciate confirmation for what types of specialty hospitals, i.e. Behavioral Health, HIMSS Analytics will consider.

No. The Acute Care EMRAM is designed for acute care facilities only. In the United States, HIMSS Analytics reviews and confirms that the hospital has acute care licensed beds on their state licensure. It becomes more complicated when the hospital has both an acute care license and a skilled care, intermediate care, or rehab care license. If there is an acute care component, then HIMSS Analytics will apply the EMRAM. They take these on a case-by-case basis.[8] Please see the HIMSS Analytics Maturity and Adoption Models page for more information regarding the other models supported.

8) Are the requirements the same for Puerto Rico hospitals or other international hospitals

Yes. The requirements are identical. HIMSS Analytics no longer supports regional EMR Adoption Models. All hospitals are now evaluated on the same EMRAM requirements.

9) How many staff from our hospital may attend the Stage 7 Award Recognition dinner at the HIMSS Annual Conference?

Each organization (not each hospital) is allocated 2 complimentary tickets to the Award Gala. Organizations can purchase extra tickets for a fee.

10) Does a hospital need to have a corporate membership with HIMSS in order to complete the HIMSS Analytics Annual Study?

No. This is not a requirement but Corporate Members do receive discounts towards the cost of the Stage 7 initial validation and subsequent revalidations. Please contact HIMSS for more information about membership benefits and pricing.

Clinical Documentation

1) *Stage 7 Requirement: Discrete data captured from vitals monitors directly interfaced into the EMR. Vital signs data automatically transmitted to the EMR are verified by nurses before being written permanently to the patient's EMR if used in the wards.* We currently have vital signs interfaced in certain ICU, ED, OB – but not house-wide. Does this meet the requirement?

Yes. These monitors are required in the ICU but may be used in order wards or in the ED. Yes, documentation is required in the OR. They expect to see OR monitors. If a hospital does not have monitors in the ICU, HIMSS will accept PACU as an alternative.[9] HIMSS would want to see and hear plans for growing your networked monitoring capability during the Stage 7 validation visit.[10]

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[8] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on January 28, 2013

[9] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 1, 2012

[10] FAQ Clarification provided by Patti Harris and John Hoyt, HIMSS Analytics in May 2012 to Phelps County Regional Medical Center

Bedside Verification – Medications, Blood Products and Expressed Human Milk

1) What reports does MEDITECH recommend for evaluating bedside verification scanning?

Medication Administration Scanning Utilization - MEDITECH recommends utilizing the standard Pharmacy eMAR Scanned/Not Scanned Report.

Blood Transfusion Scanning Utilization - MEDITECH recommends uploading custom Report #02232 to your system from our Report Archive.

Expressed Human Milk Scanning Utilization - MEDITECH recommends utilizing the standard Pharmacy eMAR Scanned/Not Scanned Report. The user will need to enter "Milk" as a Medication when pulling that report. Please see our Barcoding of Human Milk resources found on our Stage 6 & 7 Checklists & Workflow Documents page to learn the build and workflow within your MEDITECH EMR.

2) Expressed Human Milk – is this required for all hospitals?

No. Only hospitals that have shared communal storage of human milk are required to do the appropriate barcode matching.[11] This requirement applies to the NICU, Labor & Delivery, and/or Maternity wards.

3) Expressed Human Milk - is this mom to baby only or is HIMSS looking for donor milk to be barcoded too?

They are looking for communally stored mother's milk to be barcoded and scanned. Donor and pasteurized milk can be excluded from the human milk scanning rates.[12] Please see our Barcoding of Human Milk resources found on our Stage 6 & 7 Checklists & Workflow Documents page to learn the recommended build and workflow within your MEDITECH EMR.

4) How many months does a hospital need to demonstrate hitting the required Bedside Verification statistics?

A hospital needs to meet or exceed the 95% scan rate for four consecutive months prior to their Stage 7 validation visit. This includes scanning medications, blood products, and human milk in addition to the patient's wristband and/or infant ankle bracelet. Four months is a sufficient time frame for trending and that it is a permanent "fix" that a hospital will maintain the percentages moving forward.[13] These utilization rates will need to be included in your hospital's Opening Presentation to HIMSS Analytics during the Stage 7 validation visit.

5) Can any scenarios be excluded from the >= 95% Stage 7 scanning requirement for medication or blood products?

Yes. HIMSS allows certain scenarios to be excluded. For medications, any code/resuscitation medications can be administered using paper but will need to be

[11] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on April 8, 2014

[12] Clarification provided by Philip Bradley, Regional Director HIMSS Analytics, to MEDITECH via email on April 16, 2019

[13] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on February 20, 2013

entered into the patient's medication profile or eMAR before the patient transfers to the next level of care. A medication scanning exclusion also applies to anesthesia but the administered medications need to be added to the patient's medication profile or eMAR before the patient leaves the PACU.

As for blood products, HIMSS allows exclusions for the ED and OR[14] as these departments may have trauma-sensitive or mass transfusion scenarios that do not allow for scanning. These examples can be removed from the >= 95% calculation and does not count against the hospital's scan rates due to their increased level of acuity. Also, mass transfusions that occur in any in-patient units or in the ED and non-blood products such as rhogam can be omitted from the scanning requirement.[15]

Please note that observation and/or same-day surgery patients can also be omitted from the Stage 7 scanning rates as these are considered outpatient statuses.[16]

All Medications on the eMAR

1) *Stage 7 Requirement: Anesthesia medications given by anesthesiologist are entered into a manual medication record and later entered into the patient medication profile by another before the patient leaves the PACU.* Our anesthesia department documents electronically (including medications) in an anesthesia system that is interfaced to our MEDITECH EMR after the case. The medications are documented in the anesthesia template but are not re-documented on the eMAR. Is this acceptable to meet the requirement or do our anesthesia personnel need to document again on the eMAR?

The primary idea behind the requirement to have all medications listed on the eMAR to avoid having physicians looking in multiple places to find a complete medication list.[17] If the intraoperative medications are not documents on the eMAR, a pharmacist or nurse will need to re-document them on the patient's medication profile or eMAR before the patient leaves the PACU.

2) Regarding anesthesia medications being entered into the medication record: We are looking at the best options to meet this requirement and certainly do understand the importance. Our anesthesia department removes their medications from an Omnicell that sends a message to the eMAR listing the medication on the eMAR and indicating that it was dispensed for the patient. They will then document the medication in their anesthesia system. This system sends a summary report to our MEDITECH EMR system after the case. Anesthesia does not go in and re-document their actual admin on the MAR. If the medication is listed on the MAR but doesn't have the administered dose/time, is that acceptable?

The dispensing system (i.e. Omnicell) does not know the administered dose and knowing the dose is critical. If an anesthesia medication is documented without the dose, the hospital will need to update this workflow for Stage 7. [18]

Computerized Physician Order Entry (CPOE)

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[14] Clarification provided by John Hoyt, Executive VP Organizational Services at HIMSS Analytics, to MEDITECH on March 28, 2014

[15] FAQ Clarification provided by Philip Bradley, Regional Director HIMSS Analytics, to MEDITECH on March 13 & 15, 2019 via email

[16] FAQ Clarification provided by Philip Bradley, Regional Director HIMSS Analytics, to MEDITECH on March 4, 2019 via email

[17] FAQ Clarification provided by Patti Harris and John Hoyt, HIMSS Analytics in May 2012 to Phelps County Regional Medical Center

[18] FAQ Clarification provided by Patti Harris and John Hoyt, HIMSS Analytics in May 2012 to Phelps County Regional Medical Center

1) What report does MEDITECH recommend for evaluating our CPOE percentage?

MEDITECH recommends using our custom CPOE reports available on our Report Archive. Report #02166 provides a CPOE statistics report that utilizes custom sort fields. Report #02182 provides a CPOE statistics summary with no provider or order category information.

2) Would you define what counts as CPOE?

HIMSS considers any verbal, written, or telephone orders to count against the required Stage 7 utilization rate of >= 90%. Please note that standing orders/protocol orders count as CPOE and are allowed as approved by your medication committee and supported by your physicians. Exploding orders also count as CPOE. If your organization chooses to include exploding orders, for example, one order explodes to 23 orders, the hospital needs to count 23 in both the numerator and denominator.[19]

3) Does HIMSS Analytics exclude any order Statuses? For example, orders at a status of unverified or canceled as ARRA Meaningful Use/Promoting Interoperability allows these statuses to be excluded.

HIMSS Analytics excludes orders at a status of canceled and unverified. They recommend excluding these orders from the denominator to increase your CPOE count.[20]

4) What do Stage 7 hospitals typically use as an order source for protocol orders "per protocol"? If it was a verbal or telephone order based on protocol, how are they capturing this information?

HIMSS Analytics experience is that protocol orders are typically telephone orders. The physician gets called because their patient gets admitted from the ED and the physician says "execute the rule-out MI protocol" and that kicks off a pre-designed and medical staff approved order set. The key thing is that it is a pre-approved order set or protocol as opposed to the physician adding a one-off order such as "ok, order another toxicology screen" or a similar scenario.[21]

5) What is the percent of orders required to be entered by physicians? Does that include scribes?

Physicians are required to meet and maintain a >= 90% CPOE rate with no more than 10% of orders being verbal, written, or telephone for inpatients. There is no specific percent of verbal versus written versus telephone. The combined amount cannot be more than 10%. The hospital will show that they have met and maintained a >= 90% CPOE rate for at least four consecutive months before their Stage 7 validation visit.

Scribes are included as "physicians" but the expectation is that the physician is at the side of the scribe so they may assist with responding to alerts or conflicts as they appear during the ordering process. If there is evidence that the physician or surgeon is not in the area, for example, the OR when the order is written, then that process will not meet

[19] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 1, 2012

[20] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 19, 2013

[21] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 19, 2013

the requirement.[22]

6) **During the Stage 7 validation visit, the HIMSS Analytics surveyors go to the pharmacy. If the pharmacist is changing an order or dosage, they want to understand how the modification is documented. A MEDITECH customer said that their pharmacists use MEDITECH for clinical interventions. They do not send communication to physicians for all modifications. For example, if a liquid should have been an IV. Is this acceptable?**

   Yes. It is acceptable to HIMSS Analytics that the pharmacist does not send the physician a note if it is the example of switching from PO to IV.[23]

7) **What are some examples of alerts that may be specific to the ICU?**

   The statement in the Acute Care EMRAM Stage 7 Preparatory Guide is more about the HIMSS surveyors learning what your hospital might be doing rather than specific example requirements. One example may be more sensitive dosing alerts for ICU patients. It is acceptable if the alerts are the same as other inpatient wards.[24]

8) **How many months does a hospital need to demonstrate hitting the required CPOE?**

   Four consecutive months prior to the Stage 7 validation visit. Your organization needs to demonstrate that they are hitting >= 90% for CPOE and >= 95% for medications, blood products, and human milk scanning. Four months is a sufficient time frame for trending to ensure this utilization is a permanent "fix" that a hospital will maintain in the future. [25]

9) **How can we calculate the percentage of order/tasks completed by nursing within two hours of the scheduled time?**

   This was originally a requirement for Stage 7 when the 2018 EMRAM changes were released. HIMSS has updated their Preparatory Guide to note that this is no longer a requirement but is "useful for future EMRAM criteria updates."[26] MEDITECH does recommend that your organization use the standard Pharmacy eMAR Variance Report to track any medication administrations that occurred outside of the variance. Although this report does not provide a total percentage, HIMSS Analytics has confirmed that the eMAR Variance Report does meet the intent of the requirement.[27]

Physician Documentation

[22] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 1, 2012

[23] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to Centura Health on December 19, 2012

[24] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH July, 2013

[25] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on February 20, 2013

[26] HIMSS Analytics EMRAM Acute Stage 7 Preparatory Guide 2019v1, Pg. 17, Requirement 54

[27] Clarification provided by Philip Bradley, Regional Director HIMSS Analytics, to MEDITECH on April 6, 2018 via email

1) **We currently utilize a combination of structured and unstructured documentation for our physicians. For example, we still have some physicians who utilize dictation. Is there a percentage expectation or is it acceptable to have the structured templates implemented to a certain degree?**

   The difficulty in free text (unstructured) documentation is being able to use clinical decision support (CDS) within physician documentation. Therefore, the surveyors are looking to see that physician documentation is generating discrete data supported by CDS.[28]

   HIMSS Analytics recognizes that it is difficult to estimate exact percentages of discrete physician documentation. If there is 0% discrete data, then the hospital would fail to achieve Stage 7. The goal is 50% to 70% discrete data with the balance being transcription after dictation or voice recognition.[29]

2) **What are HIMSS Analytics expectations regarding speech recognition that can analyze textual content and create new, discrete data fields?**

   In physician documentation, surveyors want the organization to capture discrete data so that the data may be used in clinical decision support and clinical documentation architecture. HIMSS Analytics realizes that natural language processing (NLP) is resource intensive and most organizations do not have the capabilities. The surveyors want to see the discrete data being captured in structured documentation templates.

   A hospital would not meet the Stage 7 requirements if they are not using structured data. HIMSS Analytics understands that the ED is a higher level of acuity and all structured documentation is not realistic but they do expect ED documentation to be both template and dictation/voice recognition. For some clinical scenarios, dictation/voice recognition provides the necessary clarity the physician wants for legal protection.

   There is no percent requirement in physician documentation for discrete versus transcription/voice recognition as HIMSS Analytics feel it is too onerous to validate. As a general guideline, the surveyors would like to see 50-70% discrete data capture and 30-50% dictation/voice recognition.[30]

3) **Nursing assists with some physician documentation, does that count?**

   Yes. It is common practice. The surveyors often see 60% of physician documentation already showing up after nursing documents. This allows the same clinical decision support rules to fire within physician documentation.[31] MEDITECH's CAUTI Toolkit is an example of a nurse-driven protocol that supports physician documentation. Please see our EHR Toolkits page for more information.

4) **Do you have any clinical decision support examples from Stage 7 Pediatric**

[28] FAQ Clarification provided by Patti Harris and John Hoyt, HIMSS Analytics in May 2012 to Phelps County Regional Medical Center

[29] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 1, 2012

[30] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 1, 2012

[31] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 1, 2012

hospitals for all document types (H&P, Consult Note, Discharge Summary, Progress Note)?

Pediatric examples from other Stage 7 hospitals are typically cumulative or weight-based dosing related as dosing is critically important.

One prestigious pediatric research hospital had an interesting example. They had genetic testing result rules fire warnings to direct appropriate dosing. There are some genetic indications as to whether a pediatric patient is sensitive or insensitive to morphine. The hospital was able to use rules to verify dosing if certain genetic markers were present in the patient's chart.[32]

5) **For Stage 7, I understand that we need to have several documentation rules and/or alerts set up. Can you share with me examples of some rules that others have used? Would 3 or 5 examples be sufficient?**

This requirement is not prescriptive. Hospitals should expect to discuss three or more examples during their Opening Presentation. HIMSS would like to see the evidence to show how each rule or CDS intervention is beneficial. The surveyors would also like to observe one example during the Hospital Tour while they are watching a physician complete their documentation. The physician being surveyed should also be prepared to verbally discuss other examples. For benchmarking against other Stage 7 hospitals, the HIMSS surveyors on average see six rules deployed.[33]

6) **Exceptions to ideal, paperless workflow –Outside records are scanned upon admission or according to policy, e.g., medication history, discharge summary, latest lab values, etc. What does this mean?**

The hospital needs to have a policy related to outside records that defines what pertinent forms, i.e. discharge summary, latest labs, consult notes, etc. need to be available to the clinical staff and therefore scanned into the patient's electronic record. It is not expected that the patient's complete outside record be scanned, only records that contain clinically relevant information.

7) **Do all old films need to be scanned into PACS?**

No. Hospitals are not required to scan all old films to achieve Stage 7.[34]

8) **For radiologist documentation (structured templates for diagnostic image reports, dictation/transcription, dictation/voice recognition, directly keyed by**

[32] FAQ Clarification provided by John Hoyt, HIMSS Analytics in May 2013

[33] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH, June 2013

[34] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to Inland Northwest on October 29, 2012

a radiologist), do you want those added to the HIM Chart (below) or reported separately? If in the HIM chart, what category?

How completed? / Document Type	Handwritten[6]	Dictation /Transcription[7]	Dictation /VR[8]	Structured Forms[9]	Structured Forms with Discrete Data[10]
H&P	%	%	%	%	%
Progress Notes	%	%	%	%	%
Consult Notes	%	%	%	%	%
ED Documentation	%	%	%	%	%
Discharge Notes	%	%	%	%	%
Problem List	%	%	%	%	%
Diagnosis List	%	%	%	%	%

HIMSS Analytics real concern is the documentation from the in-patient units. In the Radiology department, HIMSS Analytics wants to learn how the documentation is completed but they do not have any requirements regarding discrete documentation. HIMSS does not recommend including radiologist documentation in the HIM table. The surveyors will question if they find that the far right columns (structured forms) have zeros and the far left column (handwritten) has high percentages.

As a side note, HIMSS Analytics confirmed that they are not reviewing pathologist documentation for the Stage 7 validation.[35]

Medication Reconciliation

1) The Emergency Department is evaluated during the Stage 7 validation. What is required for medication reconciliation in the ED?

At Stage 7, the criteria need to be live on all inpatient units. Given the acuity of care delivered in an Emergency Department, it is too difficult to enforce a percent requirement for CPOE or bedside scanning but the surveyors want to see these technologies in use. A medication reconciliation process needs to be implemented in the ED to reconcile medications from outside providers such as ambulatory clinics, physician offices, etc.[36]

Health Information Management

[35] FAQ Clarification provided by John Hoyt, HIMSS Analytics in September 2013

[36] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 1, 2012

1) Is there a threshold for percent (%) discrete data vs percent (%) scanned?

No. There is no specific threshold for discrete vs. non-discrete data. The more discrete data hospitals generate, the more they can leverage clinical decision support. HIMSS Analytics understands there may be some paper generated during the patient's visit. If so, any clinically relevant paper needs to be scanned into the patient's electronic chart within 24 hours of creation. Scanning this paper after discharge only will not meet the Stage 7 requirement.

2) There are a few paper forms that we still have and we will need to scan them into the medical record. At what point are these type of paper forms required to become electronic?

HIMSS Analytics evaluates paper documentation into two categories: Clinically Relevant and Non-Clinically Relevant. Clinically Relevant needs to be scanned into the EMR within 24 hours of creation or by the time the patient is admitted to an in-patient unit. Examples of clinically relevant paper are items such as non-native orders, complex chemotherapy orders, TPN orders, and ambulance run sheets. Please note that any strips such as telemetry strips or fetal monitoring strips are not considered clinically relevant unless there is handwriting on the strips. If a telemetry/monitoring alarm sounds, then the previous minutes of the telemetry/monitoring are clinically relevant and must be scanned within 24 hours if it is not interfaced. The surveyors will want to have a clear understanding of how this process is handled.

Non–Clinically Relevant items include authorization forms, consent forms, or other forms requiring patient signature. These need to be scanned into the system within 72 hours after discharge.[37]

3) Anesthesia Documentation scanned before the patient is transferred to a <u>recovery unit</u> or <u>before leaving OR</u>?

The comments around OR/anesthesia documentation and flow sheets is time sensitive. The medications need to be documented before the patient leaves the PACU and is transferred to the next level of care (i.e. transferred to the med/surg unit, telemetry unit, or ICU). Any other clinically relevant paper documentation needs to scan within 24 hours of creation.[38]

4) Do you need to scan clinically relevant data at the point of origin or may they scan it in medical records?

The paper can be scanned in medical records. The scanning does not need to take place at the point of origin.[39] Please see our Scanning Paper Documents resources available on our Stage 6 & 7 Checklists & Workflow Documents page for MEDITECH's recommendation to implement a HIM rounding process to satisfy this requirement.

5) HIMSS Analytics will be reviewing how non-DICOM images are scanned or

[37] FAQ Clarification provided by Patti Harris and John Hoyt, HIMSS Analytics in May 2012 to Phelps County Regional Medical Center

[38] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 1, 2012

[39] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 1, 2012

added to the EMR. What needs to be done to meet the Stage 7 requirement?

Many hospitals store non-DICOM images out on the network and often the images are not indexed in some way to easily find them within the patient's electronic chart. HIMSS Analytics wants these images to be indexed so physicians can find all the pictures for a patient when needed.[40]

The surveyors will ask how non-DICOM images are handled. For example, if digital photos are taken in the ED to document abuse or dermatology photos are taken, how are these added to the patient record? The hospital is expected to have a process whereby non-DICOM images are scanned and indexed into the patient's EMR within 24 hours from when those images were created. This criteria applies to non-DICOM images created by medical devices, cameras, or other image capture devices that are not directly interfaced to the EMR.

Disaster Recovery and Business Continuity

1) **Our hospital is working on building summary reports to be available on downtime PC's on the floor via generator circuit. Does this suffice for downtime patient information? Also, are there any requirements for the summary content?**

   Summary reports must be available on unit PC's when the system is down. These PC's need to be on a generator circuit or UPS and directly connected to a printer on a generator circuit or UPS. The summary reports need to include patient allergies, medication list, and problem/diagnosis list at a minimum. The data should also be encrypted and password protected.

   Please note that a read-only EMR is not a requirement as long as the downtime PC's and summary reports are available.[41]

2) **What does Business Continuity mean?**

   Business continuity is your hospital's disaster recovery plan in the event of downtime. Most hospitals have all their active patient's clinical data written to a PC on the unit that is off-network so that in the event of downtime, the PC is still available so nurses and physicians can print off the patient information as needed.[42]

Privacy & Security

1) **Does MEDITECH provide any recommendations to meet the IT Privacy and Security requirements related to Stage 7?**

   Privacy and Security requirements were added to the EMRAM in 2018. Please see Knowledge Base 63240 for more information regarding resources to support our customers in meeting these requirements.

[40] FAQ Clarification provided by John Hoyt, HIMSS Analytics in May 2013

[41] FAQ Clarification provided by Philip Bradley, Regional Director HIMSS Analytics, to MEDITECH on March 21, 2019 via email

[42] Clarification provided by John Hoyt, Executive VP Organizational Services HIMSS Analytics, to MEDITECH on October 1, 2012