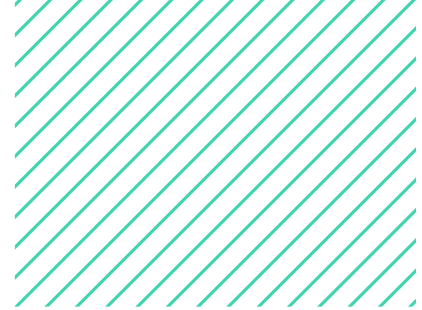


O-EMRAM

HIMSS SOLUTION



The HIMSS Outpatient EMR Adoption Model (O-EMRAM) assesses EMR adoption keeping the unique needs of outpatient facilities in mind. Achieve a near paperless environment that harnesses technology to support optimized patient care and improve care delivery with the O-EMRAM.

The stages of the model are as follows:

Stage

7

The outpatient facility no longer uses paper charts. The EMR has a mixture of structured documentation, discrete data elements to drive analytics and clinical advice, data from connected intelligent medical devices, images, test results, etc. The organization is participating in HIE with same vendor systems as well as other vendors. Disaster recovery and business continuity plans exist and are tested routinely. System governance is solid and has a demonstrable history of solving problems and adapting to requested change. Finally, the business and clinical analytics is very good and able to demonstrate improved patient care and improved population health through patient engagement.

Stage

6

Advanced clinical decision support such as protocols and pathways are in use and can be demonstrated. Health status and preventive care reminder flags are set and in use and can be demonstrated. Evidence exists and results can be shown of the beneficial use of the patient engagement program with improved health status indicators in the served patient population. There are some connected medical devices operating in the patient care areas. The clinic maintains and utilizes disease registries for case management and population health improvement.

Stage

5

A patient portal exists with capabilities to see testing results, obtain patient education material, interact with care givers, update demographic and allergy information, and schedule or request an appointment. At this point, there should be some evidence that the provider has activity to promote patient engagement, and a proportion of the patient population using the portal is known.

Stage**4**

All types of orders are entered electronically into the record by the physician or other licensed provider during the patient encounter, and clinical decision support is interacting with the orders. Physicians are documenting in the record in structured templates that produce some discrete data for interaction with clinical decision support. All lab results are electronically imported and stored in discrete structured form enabling clinical decision support interactions. Reporting to various external registries such as state immunization registries, tumor registries, and others is electronically submitted.

Stage**3**

Charting is conducted and at point of care by nursing and support personnel who room the patient and record medication history, vital signs, some history of present illness, etc. Physicians maintain an online problem list and generate e-prescribing orders during the patient encounter.

Stage**2**

The beginning of a Clinical Data Repository (CDR) exists where results from diagnostic tests reside no matter where they are generated. Other items in the repository at this point could be patient demographics, basic clinical documentation from nursing personnel, etc. completed.

Stage**1**

Physicians and nurses have desktop access to online reference material, patient eligibility information, and outside testing results in view-only mode.

Stage**0**

The organization is paper based without any online access to clinical content data or reference material.

For more information visit: www.himssanalytics.org/OEMRAM