



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Care Safety and Quality
99 Chauncy Street, 11th Floor, Boston, MA 02111
617-753-8000

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

JUDYANN BIGBY, MD
SECRETARY

JOHN AUERBACH
COMMISSIONER

Circular Letter: DHCQ 11-12-552

To: Long Term Care Facility Administrators

From: Madeleine Biondolillo, MD, Bureau Director

Subject: Use of Electronic Medical Records in Long Term Care Facilities

Date: December 27, 2011

This circular letter clarifies the conditions to be met by a facility that chooses to convert to electronic medical records (“EMR”) for health care information, medication administration and ordering of medications. The Department will deem the facility to meet the requirement that medical records be “typewritten or in ink” as stated at 105 CMR 150.013(B) and will not require a preliminary review of the particular medium by which residents’ medical records are maintained nor the system prior to implementation if a facility otherwise complies with the requirements set forth in 105 CMR 150.000, 42 CFR 483 subpart B and other relevant state and federal requirements, and meets the following conditions:

- Clinical staff is able to access all necessary clinical and pharmaceutical information at all times to provide necessary and appropriate resident care.
- The facility must have policies for use of the EMR on the premises and accessible by users at all times.
- All applicable staff, physicians, and other providers shall be adequately trained in the use of the EMR to ensure safe and quality resident care while maintaining patient privacy.
- The facility must ensure security of records including password protections and audit trails to verify entries and access, up to date antivirus software, and appropriate network security. Any data on a portable storage device, mobile computing device, or wireless transmission shall be adequately encrypted.

- Use of electronic signatures of those entering data is permissible. The facility must establish protocols and the EMR must be designed to ensure integrity, authenticity, and non-repudiation of data entered.
- The facility must ensure compliance with relevant federal and state statutes and regulations applicable to confidentiality of EMR data and protected health information.
- The facility must ensure that the system is designed and maintained to accepted industry standards and will be capable of supporting all 15 of the CMS Eligible Professional EHR Incentive Program Stage 1 Meaningful Use Core Measures, and the following “Menu Set” Measures:
 - #1 – Drug Formulary Checks
 - #2 – Clinical Lab Test Results
 - #3 – Patient Lists
 - #7 – Medication Reconciliation
 - #8 – Transition of Care Summary
 - #9 – Immunization Registries Data
- The software ensures/requires a minimum of two resident identity checks prior to data entry to prevent errors in data entry
- The facility must ensure that the system includes redundancy and other protections against possible loss, deletion or destruction of information.
- The facility must ensure that the required medical record and pharmaceutical information is and will be available at all times including during emergencies such as flooding, loss of electrical power, etc.
- Any breach of confidential information must be reported to the Department of Public Health as an incident and to appropriate state and federal authorities as required.
- The electronic information must be made readily available to regulatory personnel upon request and in the manner in which it is requested.
- The facility must maintain records for the requisite five-year retention period (105 CMR 150.013(E)).

Use of an Electronic Medical Record for medication administration and re-ordering of medications is permitted with the following additional conditions:

- The facility may use an EMR for refill orders of schedule VI medications only. Deemed approval of the use of an EMR does not allow the filling of new orders or orders for schedule II, III, IV or V medications.
- The facility must continue to use and maintain the Bound Book for narcotics and sedatives as required at 105 CMR 150.013(c)(8) and 150.008(G)(2) for all prescriptions of Schedule II-V

and the Pharmacy Record Book as required at 105 CMR 150.008(G)(4) and 150.013(C)(9) for all prescriptions ordered and received.

- The computerized prescription tracking information must be “view only” format such that the information cannot be altered by facility staff.

As part of the Facility Quality Assurance Committee program, no later than six months following the implementation of an EMR system and at least annually thereafter, the Administrator must ensure completion of an evaluation of the effectiveness and quality of the system with input and review at minimum by the medical director, director of nurses, pharmacy services, computer consultant and at least one floor nurse, and make any necessary changes based on the results of the evaluation and input, to ensure compliance and resident safety.

The Department may rescind approval for a facility’s use of an EMR upon a determination that the facility has failed to comply with the above-mentioned minimum requirements or the Department finds significant quality of care and/or resident safety concerns attributable in whole or in part to the use of the EMR system of the facility.

The facility Administrator is responsible for ensuring and providing documentation of the above-mentioned compliance.

***** SPECIAL NOTICE*****

The Improving Massachusetts Post-Acute Care Transfers (IMPACT) project engages health care organizations, starting with a pilot program in Worcester County that will support the seamless electronic transfer of clinical information for patients transitioning between hospitals, LTACs, IRFs, nursing homes, hospice, home care and PCMHs using a new electronic version of the state’s Universal Transfer Form. This form provides key health data to coordinate care for patients making the transition from one clinical setting to another.

The Universal Transfer Form contains key patient health data, including medication lists, advance directives, and treatment plans. IMPACT will create a system for information exchange between health care providers that allows organizations both with electronic health record (EHR) systems and without EHRs to efficiently and securely share information about their patients electronically.

Please be alert to the IMPACT learning collaboratives which will be convened in communities throughout the state over the next few years in order to engage health care providers across the continuum of care, and allow for the development of best practices regarding documentation, communication, patient education and other processes to ensure safe and successful transitions for all patients.

If you have any questions please contact Paul DiNatale at [1-617-753-8000] or at Paul.DiNatale@state.ma.us

