AMBULATORY FUNCTIONALITY

2007 Final Criteria - March 16, 2007

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1	F	**Identify and maintain a patient record:** Key identifying information is stored and linked to the patient record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the patient.	1. The system shall create a single patient record for each patient.	DC.1.1.1	P			
2			2. The system shall associate (store and link) key identifier information (e.g., system ID, medical record number) with each patient record.	DC.1.1.1	P			Key identifier information must be unique to the patient record but may take any system defined internal or external form.
3			3. The system shall provide the ability to store more than one identifier for each patient record.	DC.1.1.1	P			For interoperability, practices need to be able to store additional patient identifiers. Examples include an ID generated by an Enterprise Master Patient Index, a health plan or insurance subscriber ID, regional and/or national patient identifiers if/when such become available.
4			4. The system shall use key identifying information to identify (look up) the unique patient record.	DC.1.1.1	P			
5			5. The system shall provide more than one means of identifying (looking up) a patient.	DC.1.1.1	P			Examples of identifiers for looking up a patient include date of birth, phone number.
6			6. The system shall provide a field which will identify patients as being exempt from reporting functions.	DC.1.1.1	N			Examples include patients who are deceased, transferred, moved, seen as consults only. Being exempt from reporting is not the same as de-identifying a patient who will be included in reports. De-identifying patients for reporting is addressed in the "Health record output" functionality.
7			7. The system shall provide the ability to merge patient information from two patient records into a single patient record.	DC.1.1.1		N		If a duplicate chart is created, information could be merged into one chart.

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8	F	**Manage patient demographics:** Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	1. The system shall capture and maintain demographic information as part of the patient record.	DC.1.1.2	P			Examples of a minimum set of demographic data elements include: name, address, phone number and date of birth. It is assumed that all demographic fields necessary to meet legislative and regulatory (e.g., HIPAA), research, and public health requirements will be included. A desirable feature would be a method of identifying how patients would like to be contacted (e.g., alternate addresses). De-identifiying demographic information is addressed in the "Health record output" functionality.
9			2. The system shall provide the ability to include demographic information in reports.	DC.1.1.2	P			This includes using demographics to generate reports and also allows demographics to be gathered into a report. See also "Report generation" functionality.
10			3. The system shall provide the ability to maintain and make available historic information for demographic data including prior names, addresses, phone numbers and email addresses.	DC.1.1.2	N			Providers need this for look up and contact purposes, e.g., when attempting to locate a patient or family member for clinical communications.
11			4. The system shall provide the ability to modify demographic information about the patient.	DC.1.1.2	P			
12			5. The system shall store demographic information in the patient medical record in separate discrete data fields, such that data extraction tools can retrieve these data.	DC.1.1.2	N			

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13	F	**Manage problem list:** Create and maintain patient specific problem lists.	1. The system shall provide the ability to display all current problems associated with a patient.	DC.1.4.3	P			We assume current and active to mean the same thing.
14			2. The system shall provide the ability to maintain a history of all problems associated with a patient.	DC.1.4.3	P			This means both current and inactive and/or resolved problems.These may be viewed on separate screens or the same screen. Ideally each discrete problem would be listed once.
15			3. The system shall provide the ability to maintain the onset date of the problem.	DC.1.4.3	P			It is a vendor design decision whether to require complete date or free text of approximate date.
16			4. The system shall provide the ability to record the chronicity (chronic, acute/self-limiting, etc.) of a problem.	DC.1.4.3	P			
17			5. The system shall provide the ability to record the user ID and date of all updates to the problem list.	DC.1.4.3	P			
18			6. The system shall provide the ability to associate orders, medications, and notes with one or more problems.	DC.1.4.3	N			One should be able to identify all visits for a particular diagnosis/problem. Association can be made in structured data or in non-structured data.
18a			7. The system shall provide the ability to associate orders, medications and notes with one or more problems; association to be structured, codified data.				2009	
19			8. The system shall provide the ability to maintain a coded list of problems.	DC.1.4.3	P			For example: ICD-9 CM, ICD-10 CM, SNOMED-CT, DSM-IV. The Functionality WG will not specify which code set(s) are to be employed.
20			9. The system shall provide the ability to display inactive and/or resolved problems.		P			
21a			10. The system shall provide the ability to separately display active problems from inactive/resolved problems.		N			

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21b			11. The system shall provide the ability to manually order the problem list.				2009	
22	F	**Manage medication list:** Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	1. The system shall provide the ability to create and maintain medication lists.	DC.1.4.2	P			The medication list should be "patient-centric" and may include medications prescribed by any provider.
22a			2. The system shall provide the ability for the user to experssly indicate that the medication list has been reviewed; this must be a structured field.				2009	
23			3. The system shall provide the ability to record the prescribing of medications including the identity of the prescriber.	DC.1.4.2	P			
24			4. The system shall provide the ability to maintain medication ordering dates.	DC.1.4.2	P			
25			5. The system shall provide the ability to maintain other dates associated with medications including start, modify, renewal and end dates as applicable.	DC.1.4.2	P			
26			6. The system shall provide the ability to display medication history for the patient.	DC.1.4.2	P			For clarification, medication history includes all medications prescribed since the EMR was established.
27			7. The system shall provide the ability to capture medications entered by authorized users other than the prescriber.	DC.1.4.2	P			It is important to have all current medications in the system for drug interaction checking. This in the future would include the incorporation of medication history obtained from outside electronic interfaces from insurers, PBMs, etc. "User" means medical and non-medical staff who are authorized by policy to enter prescriptions or other documentation.
27a			8. The system shall provide the ability to capture, store and display medication history received electronically.			N		

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28			9. The system shall provide the ability to enter non-prescription medications, including over the counter and complementary medications such as vitamins, herbs and supplements.	DC.1.4.2	P			This is important for interaction checking, associating symptoms with supplements e.g. the L-trytophan related eosinophila-myalgia syndrome
29			10. The system shall provide the ability to exclude a medication from the current medication list (e.g., marked inactive, erroneous, completed, discontinued) and document reason for such action.	DC.1.4.2	P			Reason for removal or discontinuation may be captured as a discrete data element or as free text. In future this should be structured.
30			11. The system shall store medication information in discrete data fields such as dose, route, sig, dispense amount, refills, associated diagnoses, etc.	DC.1.4.2		N		Only approved abbreviations should be included.
31			12. The system shall provide the ability to print a current medication list.	DC.1.4.2	P			
32			13. The system shall provide the ability to display current medications only.	DC.1.4.2	P			Excluding prior medications to make current medications easier to identify. Any given medication should display only once in the list.
33			14. The system shall include standard medication codes associated with each medication in the list.	DC.1.4.2		N		It is anticipated that upcoming eRx regulation and the work of AHIC will define these in the near future. This requires publication by HITSP of an implementation guide by 3/07. This requirement will be postponed for a year after the publication of such a guide if one is not available by 3/07.

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34			15. The system shall provide the ability to enter uncoded or free text medications when medications are not on the vendor-provided medication database or information is insufficient to completely identify the medication.		M			Medications that are not on the vendor-provided medication database or not enough information is available to completely identify the medication. This could be either uncoded (Synthroid unknown dose) or free text (blue hypertension pill).
35			16. The system shall provide the ability to alert the user at the time a new medication is prescribed that drug interaction and allergy checking will not be performed against the uncoded or free text medication.		N			
36			17. The system shall provide the ability to enter or further specify in a discrete field that the patient takes no medications.		N			
37			18. The system shall provide the ability to record the date of changes made to a patient's medication list and the identity of the user who made the changes.		M			This information may appear as an optional view rather than a required view on the main screen. Need to capture the identity of the user and the date of changes made. Changes are to be recorded at the level of the individual medication.
38	F	**Manage allergy and adverse reaction list:** Create and maintain patient specific allergy and adverse reaction lists.	1.The system shall provide the ability to capture and store lists of medications and other agents to which the patient has had an allergic or other adverse reaction.	DC.1.4.1	P			The user determines what defines an allergy or adverse reaction.
39			2. The system shall provide the ability to specify the type of allergic or adverse reaction.	DC.1.4.1	N			Allergy type may be specified as a discrete data element and/or as a free text description. This should be a modifiable field.
39a			3. The system shall provide the ability to specify the type of allergic or adverse reaction in a discrete data field.				2009	Data does not need to be codified.

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40			4. The system shall provide the ability to deactivate an item from the allergy and adverse reaction list.	DC.1.4.1	P			This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely.
41			5. The system shall provide the ability to specify the reason for deactivating an allergy/allergen from the allergy list.	DC.1.4.1		N		Reason for deactivating an allergy type may be specified as a discrete data element or in non-structured data. This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely.
42a			6. The system shall provide the ability to record the deactivation of items from the allergy list.	DC.1.4.1	N			Necessary for medico-legal purposes. This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely.
42b			7. The system shall provide the ability to record the identity of the user who added, modified, inactivated or removed items from the allergy list, including attributes of the changed items.		N			Attributes include the name of the allergen, the date of the change, and the action (added, modified, inactivated or removed).

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43			8. The system shall provide the ability for a user to explicitly document that the allergy list was reviewed. The user ID and date stamp shall be recorded when the allergies reviewed option is selected.	DC.1.4.1	M			Medico-legal and regulatory compliance. This requires the user to explicitly select this option documenting that they have reviewed the allergies with the patient. Ideally this would be a structured field.
43a			9. The system shall provide the ability for a user to explicitly document, in a structured field, that the allergy list was reviewed. The user ID and date stamp shall be recorded when the allergies reviewed option is selected.				2009	Medico-legal and regulatory compliance.
44			10. The system shall provide the ability to explicitly indicate that a patient has no known drug allergies.	DC.1.4.1	P			Medico-legal and regulatory compliance. This is meant to be specific to drug allergies.
44a			11. The system shall provide the ability to explicitly indicate in a discrete field that a patient has no known drug allergies.				2009	
45			12. The system shall provide the ability to display information which has been inactivated or removed from the list as well as details of information that has been modified.	DC.1.4.1		N		Could include changing the type of reaction for a particular allergy
46			13. The system shall provide the ability to capture non-drug agents to which the patient has had an allergic or other adverse reaction.	DC.1.4.1	P			These could include items such as foods or environmental agents. This need not be accomplished within the same portion of the chart where medication allergies are noted.

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47	F	**Manage patient history:** Capture, review, and manage medical, procedural/surgical, social and family history including the capture of pertinent positive and negative histories, patient reported or externally available patient clinical history.	1. The system shall provide the ability to capture, store, display, and manage patient history.	DC.1.2	P			Examples include past medical/surgical problems, diagnoses, procedures, family history and social history.
48			2. The system shall provide the ability to capture structured data in the patient history.	DC.1.2	N			This function demonstrates the ability of a system to capture structured data but does not define the required elements of the patient history that shall be structured. Discrete data elements allow for searching and/or reporting by the EHR, and for this criterion the data could be free text or codified. Future functions would define the required patient history elements that shall be captured discretely as structured data, and where appropriate codified terminologies will be used.
49			3. The system shall provide the ability to update a patient history by modifying, adding, removing, or inactivating items from the patient history as appropriate.	DC.1.2	P			Requirement not predicated on the capture of structured data.
50			4. The system shall provide the ability to capture patient history as both a presence and absence of conditions, i.e., the specification of the absence of a personal or family history of a specific diagnosis, procedure or health risk behavior.	DC.1.2	N			Requirement not predicated on the capture of structured data.
51			5. The system shall provide the ability to capture history collected from outside sources.	DC.1.2	P			This could include data from a personal health record, online patient histories, and information from pharmacy benefit management organizations. This criterion will accept any method of entry for year one, but electronic entry of information will be required thereafter.

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52			6. The system shall provide the ability to capture patient history in a standard coded form.	DC.1.2		N		Not all data elements may currently be represented in existing standard coding schemes.
53	F	**Summarize health record**	1. The system shall provide the ability to create and display a summary list for each patient that includes, at a minimum, the active problem list, current medication list, medication allergies and adverse reactions	DC.1.1.4	P			Health record summary is at the patient level as opposed to at the level of an individual visit or episode of care.
54	F	**Manage clinical documents and notes:** Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.	1. The system shall provide the ability to create clinical documentation or notes (henceforth "documentation").	DC.1.9.1	P			
55			2. The system shall provide the ability to display documentation.	DC.1.9.1	P			
56			3. The system shall provide the ability to save a note in progress prior to finalizing the note.	DC.1.9.1	P			
56a			4. The system shall provide the ability to insert date/time stamp at the initial creation of an encounter and when the note is completed.				2009	

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57			5. The system shall provide the ability to finalize a note, i.e., change the status of the note from in progress to complete so that any subsequent changes are recorded as such.	DC.1.9.1	P			Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or finalize a clinical note. The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.
58			6. The system shall provide the ability to record the identity of the user finalizing each note and the date and time of finalization.	DC.1.9.1	P			Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or finalize a clinical note. The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.

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59			7. The system shall provide the ability to cosign a note and record the date and time of signature.		N			The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards. ASTM has developed "2003 Updated ASTM Standard Guide for Electronic Authentication of Health Care Information" to address some of these issues.
60			8. The system shall provide the ability to addend and/or correct notes that have been finalized.	DC.1.9.1	P			The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.

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60a			9. The system shall provide the ability to identify the full content of a modified note, both the original content and the content resulting after any changes, corrections, clarifications, addenda, etc. to a finalized note.				2009	This may be in the GUI or in the audit trail.
61			10. The system shall provide the ability to record and display the identity of the user who addended or corrected a note, as well as other attributes of the addenda or correction, such as the date and time of the change.	DC.1.9.1	P			Necessary for medico-legal purposes. The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.
62			11. The system shall provide the ability to enter free text notes.	DC.1.9.1	P			
63			12. The system shall provide the ability to filter, search or order notes by the provider who finalized the note.	DC.1.9.1	N			
64			13. The system shall provide the ability to filter, search or order notes by associated diagnosis within a patient record.	DC.1.9.1	N			This is intended to be the coded diagnosis and not free text in the body of a note.

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65			14. The system shall provide the ability to capture patient vital signs, including blood pressure, heart rate, respiratory rate, height, and weight, as discrete data.	DC.1.9.1	P			It is understood that vendors should support conversion to numeric values that can be graphed. Coding in ICD-9 CM, ICD-10 CM, SNOMED, UMLS, etc., would enhance interoperability and for public health surveillance or clinical research.
65a			15. The system shall be capable of indicating to the user when a vital sign measurement falls outside a preset normal range. Authorized users should set the normal ranges.				2009	
66			16. The system shall provide the ability to capture other clinical data elements, such as peak expiratory flow rate, size of lesions, severity of pain, as discrete data.	DC.1.9.1		N		
66a			17. The system shall provide the ability to display other discrete numeric clinical data elements, such as peak expiratory flow rate or pain scores, in tabluar and graphical form.				2009	Listed items are examples only.
67			18. The system shall provide the ability to associate standard codes with discrete data elements in a note.	DC.1.9.1		N		Examples include but are not limited to SNOMED-CT, ICD-9 CM, ICD-10 CM, DSM-IV, CPT-4, MEDCIN, and LOINC. This would allow symptoms to be associated with SNOMED terms, labs with LOINC codes, etc. The code associated with a note would remain static even if the code is updated in the future.
68			19. The system shall provide templates for inputting data in a structured format as part of clinical documentation.	DC.1.9.1	P			Codified data are data that is structured AND codified according to some 'external' industry accepted standard such as ICD-9 CM, ICD-10 CM, SNOMED-CT, and CPT-4.

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69			20. The system shall provide the ability to customize clinical templates.	DC.1.9.1	P			Customizations may be site specific.
70			21. The system shall provide templates for displaying medical summary data in a structured format.	DC.1.9.1		N		Examples might include the continuity of care record or the CDA. This requirement does not specify a particular format although many vendors will choose to use the harmonized CCR/CDA/CRS once available.
71a			22. The system shall be capable of recording comments by the patient or the patient's representative regarding the accuracy or veracity of information in the patient record (henceforth 'patient annotations').		N			For 2007 it is sufficient for these to be recorded as either free-text notes (see item F54) or scanned paper documents (see item F78). It is not required that the system facilitate direct entry into the system by the patient or patient's representative.
71b			23. The system shall display patient annotations in a manner which distinguishes them from other content in the system.			N		Examples include but are not limited to use of a different font or text color, a text label on the screen indicating that the comments are from a patient or patient's representative, etc. "Distinguishable" refers specifically to comments made by the patient or patient's representative, but does not refer to the individual components of that chart that they may disagree with.
~~72~~			Deleted.					

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73			24. The system shall provide the ability to identify and maintain patient or patient proxy completed clinical information.			N		Once verified by a physician and shared with other parts of the chart, the shared data does not need to be identified as patient completed in all sections where data may be shared, but the original patient completed information shall be maintained.
74			25. The system shall provide the ability to graph height and weight over time.		P			
74a			The system shall provide the ability to calculate and graph body mass index (BMI) over time.				2009	
74b			The system shall provide the ability to compare body mass index (BMI) to standard norms for age and sex over time.				2009	
~~75~~			Deleted.					
76	F	**Capture external clinical documents:** Incorporate clinical documentation from external sources.	1. The system shall provide the ability to capture and store external documents.	DC.1.1.3.1	P			Scanned documents are sufficient in 2005, granular data will be expected in the future. This covers all types of documents received by the practice that would typically be incorporated into a medical record, including but not limited to faxes, referral authorizations, consultant reports, and patient correspondence of a clinical nature.
77			2. The system shall provide the ability to receive, store in the patient's record, and display discrete lab results received through an electronic interface.	DC.1.1.3.1	P			This may be an external source such as a commercial lab or through an interface with on site lab equipment.
78			3. The system shall provide the ability to save scanned documents as images.	DC.1.1.3.1	P			

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79			4. The system shall provide the ability to receive, store in the patient's record, and display text-based outside reports.	DC.1.1.3.1	P			This could be either from an outside system or from scanning with optical character recognition. Integration here means the ability to find and display the documents within the system.
79a			5. The system shall provide the ability to index and retrieve scanned documents based on the document type, the date of the original document, and the date of scanning.				2009	
80			6. The system shall provide access to clinical images. They must be accessible from within the patient's chart and labeled and date-time stamped or included in a patient encounter document. These images may be stored within the system or be provided through direct linkage to external sources.	DC.1.1.3.1		N		These images may include but are not limited to radiographic, digital or graphical images. Eventually the goal would be to allow linkage to outside systems such as a hospital PAC system.
81			7. The system shall provide the ability to accept, store in the patient's record, and display clinical results received through an interface with an external source.	DC.1.1.3.1		N		In addition to lab and radiology reports, this might include interfaces with case/disease management programs and others.
82			8. The system shall provide the ability to accept, store in the patient's record, and display medication details from an external source.	DC.1.1.3.1			2009	External source may include a retail pharmacy, the patient, or another provider. Medication details include strength and sig. Does not imply that this date will populate the medication module; that functionality will be required in future. Year to be determined based on applicability of available standards.
83			9. The system shall provide the ability to accept, store in the patient's record, and display structured text-based reports received from an external source.	DC.1.1.3.1		N		This allows for more granular integration of data.

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84			10. The system shall provide the ability to accept, store in the patient's record, and display~~,~~ codified data received from an external source.	DC.1.1.3.1			2009	Such as those sent from another physician using a standardized format. Coding schema will be determined by HITSP and will be included in test scenarios in appropriate years.
85	F	**Generate and record patient specific instructions:** Generate and record patient specific instructions as clinically indicated.	1. The system shall provide access to patient instructions and patient educational materials, which may reside within the system or be provided through links to external sources.	DC.1.10	N			An example would be a vaccine information statement.
86			2. The system shall have the ability to provide access to medication instructions, which may reside within the system or be provided through links to external sources.	DC.1.10	P			
87			3. The system shall have the ability to provide access to test and procedure instructions that can be customized by the physician or health organization. These instructions may reside within the system or be provided through links to external sources.	DC.1.10	M			This item relates to customization of instructions, not to recording in patient record that instructions have been provided.
88			4. The system shall provide the ability to record that patient specific instructions or educational material were provided to the patient.	DC.1.10	P			This does not require automatic documentation.
89			5. The system shall provide the ability to create patient specific instructions.	DC.1.10	P			
90	F	**Order medication:** Create prescriptions or other medication orders with detail adequate for correct filling and administration.	1. The system shall provide the ability to create prescription or other medication orders with sufficient information for correct filling and administration by a pharmacy.	DC.1.7.1	P			The term pharmacy here refers to all entities which fill prescriptions and dispense medications including but not limited to retail pharmacies, specialty, and mail order pharmacies.
91			Deleted					

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92			2. The system shall provide the ability to record user and date stamp for prescription related events, such as initial creation, renewal, refills, discontinuation, and cancellation of a prescription.	DC.1.7.1	P			Security to limit prescription writing is included in I.1.2 below.
93			3. The system shall provide the ability to capture the identity of the prescribing provider for all medication orders	DC.1.7.1	P			The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.
94			4. The system shall provide the ability to cosign medication orders	DC.1.7.1		N		The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.

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95			5. The system shall provide the ability to update the medication history with the newly prescribed medications.	DC.1.7.1	P			The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.
96			6. The system shall have the ability to provide a list of medications to search from, including both generic and brand name.	DC.1.7.1	N			
97			7. The system shall provide the ability to maintain a coded list of medications.	DC.1.7.1	P			For clarification - Coding means a unique identifier for each medication. This functional requirement does not intend to require a national system of coding for medications.
98			8. The system shall provide the ability to capture common content for prescription details including strength, sig, quantity, and refills to be selected by the ordering clinician.	DC.1.7.1	P			We encourage the development of standard national abbreviations and that only approved abbreviations should be supported.
99			9. The system shall provide the ability to check for daily dose outside of recommended range for patient age (e.g., off-label dosing).			N		Year to be determined once e-prescribing sig requirements have been defined.
99a			10. The system shall provide the ability to check for dose ranges based on patient age and weight.				2009	Depends on availability of **F108** in the system.

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100			11. The system shall provide the ability to select a drug by therapeutic class.	DC.1.7.1		N		As available through 3rd-party drug databases.
101			12. The system shall provide the ability to receive, display and store information received through electronic prescription eligibility checking.			N		Will be required by e-prescribing. This criterion should maintain a record of whether the patient was eligible for coverage in the system.
102			13. The system shall provide the ability to display and store information received through health plan/payer formulary checking.	DC.1.7.1		N		If this included medications already on the medication list, a duplicate should not be created (same date, medication, strength, and prescriber). Formulary checking refers to whether a particular drug is covered.
103			14. The system shall provide the ability to reorder a prior prescription without re-entering previous data (e.g. administration schedule, quantity).	DC.1.7.1	P			
104			15. The system shall provide the ability to print and electronically fax prescriptions.	DC.1.7.1	P			Appropriate audits and security should be in place.
105			16. The system shall provide the ability to re-print and re-fax prescriptions.		P			This allows a prescription that did not come out of the printer, or a fax that did not go through, to be resent/reprinted without entering another prescription. Appropriate audits and security should be in place.
106			17. The system shall provide the ability to submit prescriptions electronically.	DC.1.7.1	N			See also line 166 (DC 3.2.2). Faxing for 2006, tentative electronic 2007 once standards are promulgated. This presupposes that the pharmacy is capable of receiving electronic prescriptions. This function relates to computer e-prescribing and not faxing. Appropriate audits and security should be in place.

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107			18. The system shall provide the ability to display a dose calculator for patient-specific dosing based on weight and age.	DC.1.7.1		N		This allows the user to enter pertinent information to calculate doses. This would be an interim step until databases are available to calculate doses automatically.
108			19. The system shall provide the ability to display patient specific dosing recommendations based on age and weight.	DC.1.7.1			2009	This would calculate automatically from pertinent information in the chart (age and weight) and should be in standard units and based on a standard periodicity. This is contingent upon availability of databases. We encourage their rapid development.
108a			20. The system shall provide the ability to display patient specific dosing recommendations based on renal function.				2010	On roadmap for 2010
109			21. The system shall have the ability to receive and display information about the patient's financial responsibility for the prescription.	DC.1.7.1		N		This could include co-payments or tier level of the drug obtained through an interface with a pharmacy benefits manager (PBM).
110			22. The system shall provide the ability to identify medication samples dispensed, including lot number and expiration date.	DC.1.7.1	N			Lot numbers and expiration date could be entered in free text or encoded.
111			23. The system shall provide the ability to prescribe fractional amounts of medication (e.g. 1/2 tsp, 1/2 tablet).	DC.1.7.1	P			Very important to prescribing for pediatric and geriatric patients.
112			24. The system shall provide the ability to prescribe uncoded medications.		N			See DC.1.4.2

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113			25. The system shall provide the ability to alert the user at the time a new medication is prescribed that drug interaction, allergy, and formulary checking will not be performed against the uncoded medication.		N			
114			26. The system shall provide the ability to update drug interaction databases.		P			This includes updating or replacing the database with a current version.
115			27. The system shall provide the ability to alert the user if the drug interaction information is outdated.			N		The drug database should have an "expiration date" based on the frequency of their updates such that when that date has passed, the user is alerted.
116			28. System shall provide the ability to allow the user to configure prescriptions to incorporate fixed text according to the user's specifications and to customize the printed output of the prescription.		P			This refers to the "written" output and language on the prescription such as specific language, dispense as written. For instance, users should be able to modify the format/content of printed prescriptions to comply with state Board of Pharmacy requirements.
117			29. The system shall provide the ability to associate a diagnosis with a prescription.		P			
118			30. The system shall provide the ability to display the associated problem or diagnosis (indication) on the printed prescription.		M			At least one diagnosis shall be able to be displayed but the ability to display more than one is desirable. Associated problem or diagnosis can be non-structured data or structured data.
119			31. The system shall have the ability to provide links to general prescribing information at the point of prescribing.			N		
120			32. The system shall provide the ability to create provider specific medication lists of the most commonly prescribed drugs with a default dose, frequency, and quantity.		N			

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121			33. The system shall provide the ability to add reminders for necessary follow up tests based on medication prescribed.			N		Does not imply that this must be an automated process.
121a			34. The system shall provide the ability to automatically add reminders for necessary follow up tests based on medication prescribed.				2009	As available through 3rd-party drug databases.
122	F	**Order diagnostic tests:** Submit diagnostic test orders based on input from specific care providers.	1. The system shall provide the ability to order diagnostic tests, including labs and imaging studies.	DC.1.7.2.2	P			This includes physicians and authorized non-physicians.
123			2. The system shall provide the ability to associate a problem or diagnosis with the order.			N		May associate more than one problem or diagnosis with the order.
124			3. The system shall provide the ability to capture the identity of the ordering provider for all test orders.		P			
125			4. The system shall provide the ability to capture applicable co-signatures for all test orders.			N		The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.
126			5. The system shall provide the ability to capture appropriate order entry detail, including associated diagnosis.	DC.1.7.2.2	P			Including associated diagnoses. It is desirable that all information for medical necessity checking be captured.

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127			6. The system shall provide the ability to display user created instructions and/or prompts when ordering diagnostic tests or procedures.	DC.1.7.2.2	N			Refers to diagnostic test or procedure specific instructions and/or prompts; not patient specific instructions and/or prompts. Instructions and/or prompts may be created by the system adminstrator. A 3rd party product may be used, providing that the instructions and/or prompts appear at the point of care.
128			7. The system shall provide the ability to relay orders for a diagnostic test to the correct destination for completion.	DC.1.7.2.2	P			Mechanisms for relaying orders may include providing a view of the order, sending it electronically, or printing a copy of the order or order requisition.
129			8. The system shall have the ability to provide a view of active orders for an individual patient.	DC.1.7.2.2	N			Additional sorts and filters may be provided by the vendors but not required.
130			9. The system shall have the ability to provide a view of orders by like or comparable type, e.g., all radiology or all lab orders.	DC.1.7.2.2	N			May include filters or sorts.
131	F	**Manage order sets:** Provide order sets based on provider input or system prompt, medication suggestions, drug recall updates.	1. The system shall provide the ability to define a set of related orders to be subsequently ordered as a group on multiple occasions.	DC.1.7.3	N			Does not imply that the system needs the ability to create an order set on the fly.
132			2. The system shall provide the ability to modify order sets.	DC.1.7.3	N			
133			3. The system shall provide the ability to include in an order set orders for medications, laboratory tests, imaging studies, procedures and referrals.	DC.1.7.3	N			
134			4. The system shall provide the ability to display orders placed through an order set either individually or as a group.	DC.1.7.3	N			Need to be able to see the individual components of the order set, rather than just the name of the order set. Does not mean to break down a lab panel into individual components.

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135			5. The system shall provide the ability for individual items in an order set to be selected or deselected.	DC.1.7.3		N		
136	F	**Manage results:** Route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	1. The system shall provide the ability to indicate normal and abnormal results based on data provided from the original data source.	DC.1.8.3	P			As each lab has it's own normal values, these should be reflected in the indication as to whether a lab is normal or abnormal.
137			2. The system shall provide the ability to display numerical results in flow sheets and graphical form in order to compare results, and shall provide the ability to display values graphed over time.	DC.1.8.3	N			It is desirable for the system indicate if abnormal results are high or low.
138			3. The system shall provide the ability to display non-numeric current and historical test results as textual data.	DC.1.8.3	P			
139			4. The system shall provide the ability to notify the relevant providers (ordering, copy to) that new results have been received.	DC.1.8.3	N			Examples of notifying the provider include but are not limited to a reference to the new result in a provider "to do" list or inbox.
140a			5. The system shall provide the ability to filter or sort results by type of test and test date.		N			
140b			6. In areas where results from multiple patients are displayed, the system shall provide the ability to filter or sort results by patient.			N		
141			7. The system shall provide the ability to forward a result to other users.	DC.1.8.3	N			
~~142~~			Deleted.					

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143			8. The system shall provide the ability to link the results to the original order.	DC.1.8.3	N			In 2007 this link can be effected manually by changing the status of the order from pending to complete. Future requirements could automate this link for certain electronically received labs although the requirement should not require that all types of orders be electronically linked to the results since the variety of result formats can be quite large (PT consult, Diabetes education...) and even the variety of lab result formats can be wide.
144			9. The system shall provide the ability for a user to attach a free text comment to a result that can be seen by another user who might subsequently view that result.	DC.1.8.3	N			
145			10. The system shall provide the ability to associate one or more images with a result.	DC.1.8.3		N		Through direct storage or links to the data.
146			11. The system shall provide the ability for a user to whom a result is presented to acknowledge the result.	DC.1.8.3	P			This is separate from audit trail.
147	F	**Manage consents and authorizations:** Create, maintain, and verify patient treatment decisions in the form of consents and authorizations when required.	1. The system shall provide the ability to capture scanned paper consent documents (covered in DC.1.1.3.1).	DC.1.3.3	P			
148			2. The system shall provide the ability to store, display and print patient consent forms.	DC.1.3.3	M			Example: Consent forms stored in the computer which are capable of being signed by the patient with either an electronic pen or a digital signature once widely available.

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148a			3. The system shall display and provide the ability for patients to electronically sign consent forms using currently available digital signature standards. Electronically signed consent forms shall be maintained within the patient medical record.				2009	
149			4. The system shall provide the ability to store and display administrative authorizations (e.g. privacy notices).	DC.1.3.3	N			Needed for HIPAA. Scanned copy is acceptable for 2007.
150			5. The system shall provide the ability to store and display patient consents associated with a specific clinical activity and provide the ability to link to that event in the patient's electronic chart.	DC.1.3.3		N		
151			6. The system shall provide the ability to chronologically display consents and authorizations.	DC.1.3.3		N		
152	F	**Manage patient advance directives:** Capture, maintain, and provide access to patient advance directives.	1. The system shall provide the ability to indicate that a patient has completed advanced directive(s).	DC.1.3.2	P			Important for appropriate use of resources at end of life and may just include a yes, no indication.
153			2.The system shall provide the ability to indicate the type of advanced directives, such as living will, durable power of attorney, or a "Do Not Resuscitate" order.	DC.1.3.2	N			This may be recorded in non-structured data or as discrete data.
154			3. The system shall provide the ability to indicate when advanced directives were last reviewed.	DC.1.3.2	N			This may be recorded in non-structured data or as discrete data.
155	F	**Support for standard care plans, guidelines, protocols:** Support the use of appropriate standard care plans, guidelines, and/or protocols for the management of specific conditions.	1. The system shall have the ability to provide access to standard care plan, protocol and guideline documents when requested at the time of the clinical encounter. These documents may reside within the system or be provided through links to external sources.	DC.2.2.1.1	P			This requirement could be met by simply including links or access to a text document. Road map would require more comprehensive decision support in the future. This includes the use of clinical trial protocols to ensure compliance.

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156			2. The system shall provide the ability to create site-specific care plan, protocol, and guideline documents.	DC.2.2.1.1	P			This includes the use of clinical trial protocols to ensure compliance. It is expected that in the future discrete data elements from other areas of the chart will populate matching fields.
157			3. The system shall provide the ability to modify site-specific standard care plan, protocol, and guideline documents obtained from outside sources.	DC.2.2.1.1	N			
~~158~~	F	**Capture variances from standard care plans, guidelines, protocols:** Identify variances from patient-specific and standard care plans, guidelines, and protocols.	Deleted.					
159			1. The system shall provide the ability to record the reason for variation from care plans, guidelines, and protocols as discrete data.				2009	
160	F	**Support for drug interaction:** Identify drug interaction warnings at the point of medication ordering	1. The system shall provide the ability to check for potential interactions between medications to be prescribed and current medications and alert the user at the time of medication ordering if potential interactions exist.	DC.2.3.1.1	P			This reduces risk of inappropriate prescribing, prevents pharmacy call backs, and can reduce malpractice liability.
161			2. The system shall provide the ability to check for potential interactions between medications to be prescribed and medication allergies and intolerances listed in the record and alert the user at the time of medication ordering if potential interactions exist.	DC.2.3.1.1	P			
162			3. The system shall provide the ability to prescribe a medication despite alerts for interactions and/or allergies being present.	DC.2.3.1.1	P			
163			4. The system shall provide the ability to set the severity level at which drug interaction warnings should be displayed.	DC.2.3.1.1	P			

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164			Deleted.					
165			5. The system shall provide the ability to document at least one reason for overriding any drug-drug or drug-allergy interaction warning triggered at the time of medication ordering.	DC.2.3.1.1	N			Necessary for medico-legal purposes.
166			6. The system shall be capable of providing proactive alerts, for patients on a given medication when they are due for required laboratory or other diagnostic studies, to monitor for therapeutic or adverse effects of the medication.	DC.2.3.1.1			2009	Limited to availability of databases.
166a			7. The system shall be capable, at the time of medication ordering, of alerting the provider that based on the results of a laboratory test, the patient may be at increased risk for adverse effects of the medication.				2009	Limited to availability of databases.
167			8. The system shall provide the ability to check whether a medication being prescribed has been noted to be ineffective for the patient in the past, and alert the user at the time of medication ordering if noted ineffectiveness exists.	DC.2.3.1.1		N		This criterion assumes that at the time a medication was discontinued, it was marked "ineffective."
168			9. The system shall provide the ability to display, on demand, potential interactions on a patient's medication list, even if a medication is not being prescribed at the time.	DC.2.3.1.1	N			
169			10. The system shall provide drug-disease interaction alerts at the time of medication ordering.			N		Within the limitations of available databases.
169a			11. The system shall provide drug-disease interaction alerts at the time of entering a problem.				2009	

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170			12. The system shall provide the ability to view the rationale for a drug interaction alert.			N		Drug reference information typically provided by drug database vendors is an example of the source to obtain the rationale.
171			13. The system shall provide the ability to check for potential interactions between a current medication and a newly entered allergy.			N		
172			14. The system shall provide the ability to generate alerts based on patient age.			N		This could be based on user defined medication lists or on standard lists such as the Beers lists.
173	F	**Support for medication or immunization administration or supply:** To reduce medication errors at the time of administration of a medication, the patient is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by-product of this checking; administration details and additional patient information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances patient education.	1. The system shall provide the ability to document medication administration.	DC.2.3.2	P			
173a			2. The system shall provide the ability to document, for any medication, the medication type, dose, time of administration, route, site, lot number, expiration date, manufacturer, and user ID as structured documentation.				2009	
174			3. The system shall provide the ability to document immunization administration.	DC.2.3.2	P			
175			4. The system shall provide the ability to document, for any immunization, the immunization type, dose, time of administration, route, site, lot number, expiration date, manufacturer, and user ID as structured documentation.	DC.2.3.2	N			
176			5. The system shall provide the ability to record an adverse reaction to a specific immunization.			N		Immunization allergies may be indicated in the Allergy section.

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177			6. The system shall provide the ability to alert a user at the time of ordering that the patient had a prior adverse reaction to that immunization.				2009	
178	F	**Support for non-medication ordering (referrals, care management)**	1.The system shall provide the ability to create referral orders with detail adequate for correct routing.	DC.2.4.2	N			This could include referrals to sub-specialists, physical therapy, speech therapy, nutritionists, and other non-medication, non-clinical order. Adequate detail includes but is not limited to: • Date • Patient name and identifier • "Refer to" specialist name, address and telephone number • "Refer to" specialty • Reason for referral • Referring physician name
179			2. The system shall provide the ability to record user ID and date/time stamp for all referral related events.	DC.2.4.2	N			Necessary for medico-legal purposes.
180	F	**Present alerts for disease management, preventive services and wellness:** At the point of clinical decision making, identify patient specific suggestions /	1. The system shall provide the ability to establish criteria for disease management, wellness, and preventive services based on patient demographic data (minimally age and gender).	DC.2.5.1	P			This includes the use of clinical trial protocols to ensure compliance.

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181		reminders, screening tests / exams, and other preventive services in support of disease management, routine preventive and wellness patient care standards.	2. The system shall provide the ability to display alerts based on established guidelines.	DC.2.5.1	P			Guidelines may be from national organizations, payers, or internal protocols. It is expected that in the future discrete data elements from other areas of the chart will populate matching fields. It is assumed that when a service is completed, this change will be immediately reflected with removal of the prompt.
182			3. The system shall provide the ability to establish criteria for disease management, wellness, and preventive services based on clinical data (problem list, current medications).	DC.2.5.1	P			Lab results in future years
183			4. The system shall provide the ability to update disease management guidelines and associated reference material.	DC.2.5.1	N			This allows the system's decision support tools to support changes in best practice guidelines.
184			5. The system shall provide the ability to update preventive services/wellness guidelines and associated reference material.	DC.2.5.1	P			
185			6. The system shall provide the ability to override guidelines.	DC.2.5.1	P			
186			7. The system shall provide the ability to document reasons disease management or preventive services/wellness prompts were overridden.	DC.2.5.1	N			Needed for medico-legal reasons and clinical decision support.
187			8. The system shall provide the ability to modify the rules or parameters upon which guideline-related alerts are based.	DC.2.5.1	N			This is necessary for modifications as guidelines change or practices wish to adhere to more stringent levels for example, using a HbA1c target of 6.5% instead of 7%.

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188			9. The system shall provide the ability to document that a preventive or disease management service has been performed based on activities documented in the record (e.g., vitals signs taken).	DC.2.5.1	N			
189			10. The system shall provide the ability to document that a disease management or preventive service has been performed with associated dates or other relevant details recorded.	DC.2.5.1	N			This could include services performed internally or external to the practice.
189a			11. The system shall provide the ability to individualize alerts to address a patient's specific clinical situation.		M			This is done at the patient level. Examples include but are not limited to: • Remove mammography for woman that has had a mastectomy • Remove annual pap smear alert for a woman who has had a complete hysterectomy. • Inactivate an alert for routine colon cancer screening in a patient who is terminally ill.
190	F	**Notifications and reminders for disease management, preventive services and wellness:** Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	1. The system shall provide the ability to identify preventive services, tests, or counseling that are due on an individual patient.	DC.2.5.2	P			In the future, the system should perform this automatically and proactively "contact" patient(s) without physician intervention (e.g. automated reminder letter). These guidelines might come from national organizations, medical societies, etc.
191			2. The system shall provide the ability to display reminders for disease management, preventive, and wellness services in the patient record.	DC.2.5.2	P			It is expected that in the future discrete data elements from other areas of the chart will populate matching fields.
192			3. The system shall provide the ability to identify criteria for disease management, preventive, and wellness services based on patient demographic data (age, gender).	DC.2.5.2	P			

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193			4. The system shall provide the ability to identify criteria for disease management, preventive, and wellness services based on clinical data (problem list, current medications, lab values).	DC.2.5.2	N			
194			5. The system shall provide the ability to modify the guidelines that trigger the reminders.	DC.2.5.2	P			
195			6. The system shall provide the ability to notify the provider that patients are due or are overdue for disease management, preventive, or wellness services.	DC.2.5.2	P			
196			7. The system shall provide the ability to produce a list of patients who are due or are overdue for disease management, preventive, or wellness services.	DC.2.5.2	P			
197			8. The system shall provide the ability to automatically generate letters to remind the patient or the patient's guardian of services that are due.	DC.2.5.2		N		Reminders that include PHI must be delivered through HIPAA-compliant means.
197a			9. The system shall provide the ability to automatically generate an electronic reminder to the patient or the patient's guardian of services that are due.				2009	Reminders that include PHI must be delivered through HIPAA-compliant means.
198	F	**Clinical task assignment and routing:** Assignment, delegation and/or transmission of tasks to the appropriate parties.	1. The system shall provide the ability to create and assign tasks by user or user role.	DC.3.1.1	P			Examples of tasks are messages, notifications, inbox items, worklist to-do's. This task assignment refers to internal users. External tasks would be handled under ordering section.
199			2. The system shall provide the ability to present a list of tasks by user or user role.	DC.3.1.1	N			Examples of tasks are messages, notifications, inbox items, worklist to-do's. This task assignment refers to internal users. External tasks would be handled under ordering section.
200			3.The system shall provide the ability to re-assign and route tasks from one user to another user.	DC.3.1.1	N			

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201			4. The system shall provide the ability to designate a task as completed.	DC.3.1.1	P			
202			5. The system shall provide the ability to remove a task without completing the task.	DC.3.1.1	P			Removing a task eliminates it from an individual user's "to do" list, not from audit logs, etc.
203			6. The system shall provide the ability to automatically escalate incomplete tasks to the appropriate supervisor or authority.	DC.3.1.1			2009	Escalation can be based on elapsed time or time of day.
204	F	**Inter-provider communication:** Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other encounters) and generate paper message artifacts where appropriate.	1. The system shall provide the ability to document verbal/telephone communication into the patient record.	DC.3.2.1	P			
205			2. The system shall provide the ability to incorporate paper documents from external providers into the patient record.	DC.3.2.1	P			
206			3. The system shall support messaging between users.	DC.3.2.1	P			Results and other patient data could be included. As clarification, messaging is defined as any text string sent from one person to another in the office.
207	F	**Pharmacy communication:** Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	1. The system shall have the ability to provide electronic communication between prescribers and pharmacies or other intended recipients of the medication order.	DC.3.2.2	P			Until electronic standards are established, FAX is a suitable means of transmission.
208			2. The system shall provide the ability to electronically communicate from the prescriber to the pharmacy an initial medication order as well as renewals of an existing order.	DC.3.2.2	N			
208a			3. The system shall have the ability to electronically communicate cancellations from the prescriber to the pharmacy.			N		

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209			4. The system shall provide the ability to capture and display any renewal requests received electronically from or on behalf of any dispensing entity.	DC.3.2.2	N			This refers to e-prescribing.
209a			5. The system shall provide the ability to capture and display notification of prior authorizations received electronically from or on behalf of any dispensing entity.				2009	Dependent upon standards development and availability
210	F	**Provider demographics:** Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the practice of medicine.	1. The system shall provide the ability to maintain a directory of all clinical personnel who currently use or access the system.	S.1.3.1	P			
211			2. The system shall provide the ability to maintain a directory which contains identifiers required for licensed clinicians to support the practice of medicine including at a minimum state medical license, DEA, NPI, and UPIN number.	S.1.3.1	N			This directory may be the same as that in criterion #1 for this functionality.
212			3. The system shall provide the ability to maintain a directory that stores user attributes required to determine the system security level to be granted to each user.	S.1.3.1	P			This directory may be the same as that in criterion #1 for this functionality.
213			4. The system shall allow authorized users to update the directory.	S.1.3.1	P			
214			5. The system shall provide the ability to create and maintain a directory of clinical personnel external to the organization who are not users of the system to facilitate communication and information exchange.	S.1.3.1	M			This directory may be the same as that in criterion #1 for this functionality.

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215	F	**Scheduling:** Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of patient care, for either the patient or a resource/device.	1. The system shall provide the ability to display a schedule of patient appointments, populated either through data entry in the system itself or through an external application interoperating with the system.	S.1.6	P			
216	F	**Report Generation:** Provide report generation features for the generation of standard and ad hoc reports	1. The system shall provide the ability to generate reports of clinical and administrative data using either internal or external reporting tools.	S.2.2	N			Needed for pay for performance, quality improvement activities. All data that is entered in a structured format should be individually reportable.
217			2. The system shall provide the ability to generate reports consisting of all or part of an individual patient's medical record (e.g. patient summary).	S.2.2	P			Report format may be plain text.
218			3. The system shall provide the ability to generate reports regarding multiple patients (e.g. diabetes roster).	S.2.2	N			Any disease registry might be included.
219			4. The system shall provide the ability to specify report parameters (sort and filter criteria) based on patient demographic and clinical data (e.g., all male patients over 50 that are diabetic and have a HbA1c value of over 7.0 or that are on a certain medication).	S.2.2	N			Minimum demographic data are age and gender.
220			5. The system shall provide the ability to access reports outside the EHR application.	S.2.2	P			For example, printed output, export to a file, etc.
221			6. The system shall provide the ability to produce reports based on the absence of a clinical data element (e.g., a lab test has not been performed or a blood pressure has not been measured in the last year).	S.2.2		N		

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222			7. The system shall provide the ability to save report parameters for generating subsequent reports.	S.2.2	N			
223			8. The system shall provide the ability to modify one or more parameters of a saved report specification when generating a report using that specification.	S.2.2		N		
224	F	**Health record output:** Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	1. The system shall provide the ability to define one or more reports as the formal health record for disclosure purposes.	S.2.2.1	N			This allows the practice to not print demographics, certain confidential sections, or other items. Report format may be plain text initially. In the future there will be a need for structured reports as interoperability standards evolve.
225			2. The system shall provide the ability to generate hardcopy or electronic output of part or all of the individual patient's medical record.	S.2.2.1	P			This could include but is not limited to the ability to generate standardized reports needed for work, school, or athletic participation.
226			3. The system shall provide the ability to generate hardcopy and electronic output by date and/or date range.	S.2.2.1	M			

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227			4. The system shall provide the ability to export structured data which removes those identifiers listed in the HIPAA definition of a limited dataset. This export on hardcopy and electronic output leaves the actual PHI data unmodified in the original record.	S.2.2.1		N		De-identifying data on hardcopy or electronic output is necessary for research. However, it must be emphasized that this function is not intended to cleanse the text in the note or data in the original record. As per HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, identifiers that shall be removed are: 1. Names; 2. Postal address information, other than town or city, state and zip code; 3. Telephone numbers; 4. Fax numbers; 5. Electronic mail addresses; 6. Social security numbers; 7. Medical record numbers; 8. Health plan beneficiary numbers; 9. Account numbers; 10. Certificate/license numbers; 11. Vehicle identifiers and serial numbers, including license plate numbers; 12. Device identifiers and serial numbers; 13. Web Universal Resource Locators (URLs); 14. Internet Protocol (IP) address numbers; 15. Biometric identifiers, including finger and voice prints; and 16. Full face photographic images and any comparable images.

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228			5. The system shall provide the ability to create hardcopy and electronic report summary information (procedures, medications, labs, immunizations, allergies, and vital signs).	S.2.2.1	P			The report that's produced should be organized by section to make it easier to read.
229			6. The system shall have the ability to provide support for disclosure management in compliance with HIPAA and applicable law.		N			This criterion may be satisfied by providing the ability to create a note in the patient's record. More advanced functionality may be market differentiators or requirements in later years.
230	F	**Encounter management:** Manage and document the health care delivered during an encounter.	1. The system shall provide the ability to document a patient encounter.	S.3.1	P			
231			2. The system shall provide the ability to document encounters by one or more of the following means: direct keyboard entry of text; structured data entry utilizing templates, forms, pick lists or macro substitution; dictation with subsequent transcription of voice to text, either manually or via voice recognition system.	S.3.1	P			This does not preclude entry via new technologies.
232			3. The system shall provide the ability to associate individual encounters with diagnoses.	S.3.1	P			
233			4. The system shall have the ability to provide filtered displays of encounters based on encounter characteristics, including date of service, encounter provider and associated diagnosis.	S.3.1	N			
234	F	**Rules-driven financial and administrative coding assistance:** Provide financial and administrative coding assistance based on the structured data available in the encounter documentation.	1. The system shall have the ability to provide a list of financial and administrative codes.	S.3.2.2	P			For example, ICD-9 CM, ICD-10 CM, and CPT-4 codes.
235			2. The system shall provide the ability to select an appropriate CPT Evaluation and Management code based on data found in a clinical encounter.	S.3.2.2	P			May be accomplished via a link to another application.

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236			3. The system shall have the ability to provide assistance in selecting appropriate billing codes based on codified clinical information in the encounter.	S.3.2.2		N		Criterion satisfaction will require that the system can automatically count elements in the history and examination documentation to accomplish this calculation. MDM complexity will still require specification by the provider/coder.
~~237~~			Deleted.					
238	F	**Eligibility verification and determination of coverage**	1. The system shall provide the ability to display medical eligibility obtained from patient's insurance carrier, populated either through data entry in the system itself or through an external application interoperating with the system.	S.3.3.2	M			The EHR need only provide information for the physician as to whether the patient is covered by that insurance plan. This can be accomplished by a text note following telephone verification.
239			2. The system shall be capable of receiving and displaying prescription benefits eligibility information.	DC.1.7.1		N		Will be required by e-prescribing
240	F	**Manage Practitioner/Patient relationships:** Identify relationships among providers treating a single patient, and provide the ability to manage patient lists assigned to a particular provider.	1. The system shall provide the ability to identify by name all providers associated with a specific patient encounter.	S.3.4	P			A provider is defined as anyone delivering clinical care such as physicians, PAs, CNPs and nurses; the provider is the person who completes the note.
241			2. The system shall provide the ability to specify the role of each provider associated with a patient, such as encounter provider, primary care provider, attending, resident, or consultant.			N		This is simply meant as a means to define the provider role. Display of that data is not addressed.
242			3. The system shall provide the ability to specify the primary or principal provider responsible for the care of a patient within a care setting.		N			
243			4. The system shall provide the ability to create a list of all patients who have had an encounter with a given provider.			N		

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244	F	**Clinical decision support system guidelines updates:** Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material	1. The system shall provide the ability to update the clinical content or rules utilized to generate clinical decision support reminders and alerts.	S.3.7.1	P			Growth charts, CPT-4 codes, drug interactions would be an example. Any method of updating would be acceptable. Content could be third party or customer created.
245			2. The system shall provide the ability to update clinical decision support guidelines and associated reference material.	S.3.7.1	P			Any method of updating would be acceptable. Content could be third party or customer created.
~~246~~	F	**Entity Authorization:** Manage the sets of access control permissions granted to entities that use an EHR-S. Enable EHR-S security administrators to grant authorizations to users for roles, and within contexts. A combination of the authorization levels may be applied to control access to EHR-S functions or data within an EHR-S, including at the application or the OS level.	Deleted.					
247		**Enforcement of confidentiality:** Enforce the applicable jurisdiction's patient privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	1. The system shall provide the ability to audit the date/time and user of each instance when a patient chart is printed by the system.	I.1.9	N			Does not include screen print and other functions that are outside the EHR system.
248			2. The system shall provide a means to document a patient's dispute with information currently in their chart.	I.1.9		N		This does not imply that the patient can document directly in their chart. Some methods include but are not limited to allowing the patient a view only access to their record, printing a copy of the record for a patient to review. Methods to include the information in the chart could be as a note, a scanned copy of patient comments, an addendum to the note or other method not described.

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249			3. The system shall provide the ability to identify all users who have accessed an individual's chart over a given time period, including date and time of access.	I.1.9	N			Specific items/sections of information accessed shall be identified, with appropriate audit trail.
250			4. The system shall provide the ability to identify certain information as confidential and only make that accessible by appropriately authorized users.	I.1.9		N		This may be implemented by having a "confidential" section of the chart
251			5. The system shall provide the ability to prevent specified user(s) from accessing a designated patient's chart	I.1.9		N		An example would be preventing access to a VIP or staff member's chart. When access is restricted, the system shall provide a means for appropriately authorized users to "break the glass" for emergency situations. Such overrides should be audited.
252	**F**	**Data retention, availability, and destruction:** Retain, ensure availability, and destroy health record information according to organizational standards. This includes: Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	1. The system shall provide the ability to retain data until otherwise purged, deleted, archived or otherwise deliberately removed.	I.2.1	P			
253			2. The system shall provide a method for archiving health record information.	I.2.1			2009	Archiving is used to mean information stored in a retrievable fashion without defining where or how it is stored.
253a			3. The system shall provide the ability to retrieve information that has been archived.				2009	Retrieval does not imply restoration to current version of the software.
~~254~~			Deleted.					

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P = Previous Criteria

N = New for Year

M = Modified for Year

Original line # Phase I	WG	Category and Description	Specific Criteria	Source or References* (* See reference list at end of document)	Compliance: Certify in May 2007	Compliance: Roadmap for May 2008	Compliance: Roadmap for May 2009 and beyond	Discussion / Comments
255	F	**Audit trail:** Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.	1. The system shall provide the ability to log outgoing information exchange in an auditable form.	I.2.2		N		In future, the work group will clarify details of what should be included in the log, and revise timing of this criterion based on those elements, if required.
256			2. The system shall provide the ability to log the receipt of documents in an auditable form.	I.2.2		N		
257	F	**Extraction of health record information:** Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	1. The system shall provide the ability to export (extract) pre-defined set(s) of data out of the system	I.2.4	N			For example, export of performance measures, ability to query data base, chronic disease management tools.
258			2. The system shall provide the ability to import data into the system	I.2.4	N			Data import implies receiving discrete data into the EHR in an automated manner as opposed to manual data entry or document scanning. This could be accomplished via a real time or batch interface or a manual data load.
259			3. The system shall provide the ability remove discrete patient identifiers.	I.2.4	N			De-identification is necessary for research purposes, e.g., to identify patterns of disease. External applications can be used to meet this criteria.

AMBULATORY FUNCTIONALITY

2007 Final Criteria - March 16, 2007

For 2007 Certification of Ambulatory EHRs

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260			4. The system shall provide the ability to specify the intended destination of the extracted information.	I.2.4		N		The user may indicate to whom they are sending results. The lack of control of information once it leaves the practice is acknowledged.
261	F	**Concurrent Use:** EHR system supports multiple concurrent physicians through application, OS and database.	1. The system shall provide the ability for multiple users to interact concurrently with the EHR application.	Ontario 5.6.1.a	P			
262			2. The system shall provide the ability for concurrent users to simultaneously view the same record.	Ontario 5.6.1.a	P			
263			3. The system shall provide the ability for concurrent users to view the same clinical documentation or template.	Ontario 5.6.1.a	P			
264			4. The system shall provide protection to maintain the integrity of clinical data during concurrent access.	Ontario 5.6.1.a, I.1.9	P			To prevent users from simultaneously attempting to update a record with resultant loss of data

References:

1) DC, I and S prefixed references are from: HL7 EHR-S Functional Model, Release 1 - September 2006 from www.hl7.org.

2) Ontario specification refereneces are from: Ontario Medical Association, CMS Local Solution Specification V1.3. Copy located at: http://www.ontariomd.ca/cms/infoForVendors.shtml