

CCHIT: FUNCTIONALITY		For 2006 Certification of Ambulatory EHRs			Effective May 1, 2006
Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
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	1. The system shall create a single patient record for each patient.	Done	[Patients select patient]	
	2	2. The system shall associate (store and link) key identifier information (e.g., system ID, medical record number) with each patient record.	Done	[Patient select patient by acct#, name, ssn, birthdate, alternate id#, family acct#, national ID#]	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 store more than one identifier for each patient record.	Done	[Patient select patient by acct#, name, ssn, birthdate, alternate id#, family acct#, National ID#]	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.	Done	[Patient select patient by acct#, name, ssn, birthdate, alternate id#, family acct#, national ID#]	
	5	5. The system shall provide more than one means of identifying (looking up) a patient.	Done	[Patient select patient by acct#, name, ssn, birthdate, alternate id#, family acct#, national ID#]	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.		Patient can be flagged as "inactive". [select pt select Misc tab click Mk Inactive button]	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. Deidentifying patients for reporting is addressed in the "Health record output" functionality.

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
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.					
	8	1. The system shall capture and maintain demographic information as part of the patient record.	Done	[Patient select patient]	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). Deidentifying demographic information is addressed in the "Health record output" functionality.
	9	3. The system shall provide the ability to include demographic information in reports.	Done	[Patient print selective print select or enter filter info click Print]	This includes using demographics to generate reports and also allows demographics to be gathered into a report. See also "Report generation" functionality.
	11	5. The system shall provide the ability to modify demographic information about the patient.	Done	[Patient select patient edit]	
Manage problem list: Create and maintain patient specific problem list.					
	13	1. The system shall display all current problems associated with a patient.	Done	[Patient select patient Medical Records Problems]	We assume current and active to mean the same thing.
	14	2. The system shall maintain a history of all problems associated with a patient.	Done	[Patient select patient Medical Records Problem List]	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.	Done	[Patient select patient Medical Records Problem List add problem by selecting from chart on right hand side]	It is a vendor design decision whether to require complete date or free text of approximate date.

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	16	4. The system shall provide the ability to record the chronicity (chronic, acute/self-limiting, etc.) of a problem.	Done	[Patient select patient Medical Records Problem List edit problem]	
	17	5. The system shall record the user ID and date of all updates to the problem list.	Done	[Patient select patient Medical Records Problem List Hx]	
	19	7. The system shall provide the ability to maintain a coded list of problems.	Done	[Patient select patient Medical Records Problem List]	For example, ICD-9, SNOMED-CT, DSMIV. The Functionality WG will not specify which code set(s) are to be employed.
	20	8. The system shall provide the ability to display inactive and/or resolved problems.	Done	[Patient select patient Medical Records Problem List click column to toggle active or inactive, resolved or not resolved]	
Manage medication list: Create and maintain patient specific medication lists- Please see DC.1.3.1 for medication ordering as there is some overlap.					
	22	1. The system shall create and maintain medication lists.	Done	[select patient Medical Records select [Active Medications] from Summary screen, or select Medications from menu on right hand side]	The medication list should be "patientcentric" and may include medications prescribed by any provider.
	23	2. The system shall record the prescribing of medications including the identity of the prescriber.	Done	[select patient Medical Records Medications select medication add]	
	24	3. The system shall maintain medication ordering dates.	Done	[select patient Medical Records Medications select medication add]	
	25	4. The system shall maintain other dates associated with medications including start, modify, renewal and end dates as applicable.	Done	[select patient Medical Records Medications edit/add medication]	
	26	5. The system shall display medication history for the patient.	Done	[select patient Medical Records Medications print]	For clarification, medication history includes all medications prescribed since the EMR was established.

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	27	6. The system shall capture medications entered by authorized users other than the prescriber.	Done	PTP maintains a field for the initials of the "Entry person". This is separate from the Ordering Provider. [select pt Medical Records Medications add or edit medication]	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 nonmedical staff who are authorized by policy to enter prescriptions or other documentation.
	28	7. The system shall provide the ability to enter nonprescription medications, including over the counter and complementary medications such as vitamins, herbs and supplements.	Done	[select pt Medical Records Medication add or edit medication]	This is important for interaction checking, associating symptoms with supplements e.g. the L-tryptophan related eosinophilamyalgia syndrome
	29	8. 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.	Done	[select pt Medical Records Medication select medication click Disc enter reason to discontinue]	Reason for removal or discontinuation may be captured as a discrete data element or as free text. In future this should be structured.
	31	10. The system shall provide the ability to print a current medication list.	Done	[select pt Medical Records Medication print]	~
	32	11. The system shall provide the ability to display current medications only.	Done	[select pt Medical Records Medication check Active Only click print]	Excluding prior medications to make current medications easier to identify. Any given medication should display only once in the list.
Manage allergy and adverse reaction list: Create and maintain patient specific allergy and adverse reaction lists.					
	38	1.The system shall capture and store lists of medications and other agents to which the patient has had an allergic or other adverse reaction.	Done	[select pt Medical Records Allergies select from Chart of Allergies]	The user determines what defines an allergy or adverse reaction.
	40	3. The system shall provide the ability to remove an item from the allergy and adverse reaction list.	Done	[select pt Medical Records Allergies select allergy click "-" to remove]	This could include removal, marking as erroneous, or marking as inactive.
	44	7. The system shall provide the ability to explicitly indicate that a patient has no known drug allergies.	Done	[select pt Medical Records Allergies click "No Known Drug Allergies"]	Medico-legal and regulatory compliance. This is meant to be specific to drug allergies.

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	46	9. The system shall capture non-drug agents to which the patient has had an allergic or other adverse reaction.	Done	[select pt Medical Records Allergies add or edit allergy]	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.
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.					
	47	1. The system shall capture, store, display, and manage patient history.	Done	[select patient Medical Records select Past History tab at the top]	Examples include past medical/surgical problems, diagnoses, procedures, family history and social history.
	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.	Done	[select patient Medical Records select Past History tab at the top click on the (underlined) Past Medical History label at the top add]	Requirement not predicated on the capture of structured data.
	51	5. The system shall capture history collected from outside sources.	Done	[select patient Medical Records select Past History tab at the top click on the (underlined) Past Medical History label at the top click Documents]	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.
Summarize health record					
	53	1. The system shall 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	Done	[select patient Medical Records the summary is displayed on left hand side]	Health record summary is at the patient level as opposed to at the level of an individual visit or episode of care.
Manage clinical documents and notes: Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.					

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	54	1. The system shall create clinical documentation or notes (henceforth "documentation").	Done	[select patient Medical Records Add note]	
	55	2. The system shall display documentation.	Done	[select patient Medical Records Add note]	
	56	3. The system shall save a note in progress prior to finalizing the note.	Done	[select patient Medical Records Add note] (Clicking the Close button will finalize a note)	
	57	4. 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.	Done	[select patient Medical Records select medical note by double clicking click Close button]	Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or sign off 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	5. The system shall record the identity of the user finalizing each note and the date and time of finalization.	Done	PTP records who closed the note. When you display a closed note, you will see the initials, date and time of person who closed the note at the top of the screen in red.	Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or sign off 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.

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	60	7. The system shall provide the ability to addend and/or correct notes that have been finalized.	Done	A closed note must be re-opened. From PTP desktop, select [Utilities Trans, Proc, eTicket & Med Note Utilities Restore closed trans, eTickets, medical notes select Medical Note tab select note click Restore button]; this action is noted in note history.	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.
	61	8. The system shall 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.	Done	[select pt Medical Records select Medical note and double click to edit click Hx in upper left hand corner to display modification history]	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	9. The system shall provide the ability to enter free text notes.	Done	All note formats allow free text. [select pt Medical Records add or edit note]	
	63	10. The system shall provide the ability to filter, search or order notes by the provider who finalized the note.	Done	[ptp desktop Medical pt Medical Notes select "closed by" from dropdown box at top of screen]	
	65	12. The system shall capture patient vital signs, including blood pressure, heart rate, respiratory rate, height, and weight, as discrete data.	Done	[select pt Medical Records Vitals add or edit vitals]	It is understood that vendors should support conversion to numeric values that can be graphed.
	68	15. The system shall provide templates for inputting data in a structured format as part of clinical documentation.	Done	[select pt Medical Records Data Add select data template from dropdown box click Add NOW]	Codified data are data that is structured AND codified according to some 'external' industry accepted standard such as ICD-9, SNOMED-CT, and CPT-4.
	69	16. The system shall provide the ability to customize clinical templates.	Done	Data templates can be customized by selecting [ptp desktop Utilities Medical Records Utilities Setup EMR Data click "+" to add new template]	Customizations may be site specific.

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	72	19. The system shall link disputed information to the original entry.	Done	[select pt Medical Records add or edit medical note click "Dis" (for Disputed) at top left corner]	This may be managed as an addendum at the document level.
	74	21. The system shall provide the ability to graph height and weight over time.	Done	[select pt Medical Records Vitals add or edit vitals (height and weight)]; to graph, select [GrCht select age range]	
Capture external clinical documents: Incorporate clinical documentation from external sources.					
	76	1. The system shall provide the ability to capture and store external documents.	Done	From within pt record or Medical Record, select [Documents], then scan or browse for documents.	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 receive, store in the patient's record, and display discrete lab results received through an electronic interface.	Done	[select pt <select John Doe if using PTP Demo> Medical Records Lab Results Click Display] [Lab Results can display results in HL7 or pdf formats]	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.	Done	From within pt record or Medical Records select [Documents Scan] [Scanner must be Twain compatible] Images are saved	
	79	4. The system shall receive, store in the patient's record, and display text-based outside reports.	Done	From within pt record or Medical Records, select [Documents select folder Browse for file] [Files are saved in selected pt document folder] [Double click to display file]	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.
Generate and record patient specific instructions: Generate and record patient specific instructions as clinically indicated.					

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	86	2. The system shall provide access to medication instructions, which may reside within the system or be provided through links to external sources.	Done	Medication Instructions can be attached to each formulary entry. This must be setup first. [ptp desktop Medical Formulary select medication edit medication select Patient Literature tab browse for document on right hand side enter description click 2. Log Document] When you prescribe medication, the pt literature will be displayed, just double click to print]	
	88	4. The system shall provide the ability to record that patient specific instructions or educational material were provided to the patient.	Done	[select pt Medical Records add or edit medication select pt literature in box on right hand side by double clicking] To view patient literature handed out, select the Miscellaneous tab on the medication listing screen]	This does not require automatic documentation.
	89	5. The system shall provide the ability to create patient specific instructions.	Done	[select pt Medical Records add or edit medication enter info in "Comments to Patient" field on the Misc tab]	
Order medication: Create prescriptions or other medication orders with detail adequate for correct filling and administration.					
	90	1. The system shall create prescription or other medication orders with sufficient information for correct filling and administration by a pharmacy.	Done	[select pt Medical Records add or edit medication]	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.
	92	3. The system shall record user and date stamp for prescription related events, such as initial creation, renewal, refills, discontinuation, and cancellation of a prescription.	Done	[select pt Medical Records add or edit medication]	Security to limit prescription writing is included in I.1.2 below.

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	93	4. The system shall capture the identity of the prescribing provider for all medication orders	Done	[select pt Medicaion Records add or edit medication] [Identity of the prescribing provider can be found in Doctor field]	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 appropraite digital signature standards are available, certification criteria may be introduced using such standards.
	95	6. The system shall update the medication history with the newly prescribed medications.	Done	PTP maintains a medication history of all modifications	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 appropraite digital signature standards are available, certification criteria may be introduced using such standards.
	97	8. The system shall maintain a coded list of medications.	Done	[ptp desktop Medical Formulary edit] Each medication has a NDC number	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	9. The system shall capture common content for prescription details including strength, sig, quantity, and refills to be selected by the ordering clinician.	Done	[select pt Medical Records Medications add or edit medications] Each field (dose, sig, qty, refill, etc) is presented	We encourage the development of standard national abbreviations and that only approved abbreviations should be supported.
	103	14. The system shall provide the ability to reorder a prior prescription without re-entering previous data (e.g. administration schedule, quantity).	Done	[select pt Medical Records Medications add or edit medication select for printing by checking "prt" checkmark "FAX" click Rx]	
	104	15. The system shall provide the ability to print and electronically fax prescriptions.	Done	[select pt Medical Records Medications add or edit medication select for printing by checking "prt" checkmark "FAX" click Rx]	

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	105	16. The system shall provide the ability to re-print and re-fax prescriptions.	Done	[select pt Medical Records Medications click the "prt" to select which meds to reprint check Fax for faxing click Rx or All Rx to print or fax]	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.
	111	22. The system shall provide the ability to prescribe fractional amounts of medication (e.g. 1/2 tsp, 1/2 tablet).	Done	[select pt Medical Records Medications add or edit medication enter fractional amount in Sig or Quantity]	Very important to prescribing for pediatric and geriatric patients.
	114	25. The system shall provide the ability to update drug interaction databases.	Done	From PTP desktop, select [Medical Formulary edit medication select Drug-Drug tab click add select each drug that has an interaction, and indicate whether the interaction is fatal]; you can replace/update the entire formulary with interactions by downloading the zipped files from the Practice Today website.	This includes updating or replacing the database with a current version.
	116	27. System shall 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.	Done	Create Rx with the integrated editor: [Main menu Editor]; Select the Rx format in the Prescription Utility: [Main menu Utilities Medical Record Utilities Prescription Setup select format #5]; Print Rx from pt's medical record.	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	28. The system shall provide the ability to associate a diagnosis with a prescription.	Done	[select pt Medical Records Medication add or edit medication enter diagnoses on the Misc tab] PTP will place the medical diagnoses on the prescription by default. Use this feature only if you want a specific diagnosis always associated with this prescription.	
Order diagnostic tests: Submit diagnostic test orders based on input from specific care providers.					
	122	1. The system shall provide the ability to order diagnostic tests, including labs and imaging studies.	Done	[select pt Medical Records Labs select lab test by double clicking]	This includes physicians and authorized non-physicians.

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	124	3. The system shall capture the identity of the ordering provider for all test orders.	Done	[select pt Medical Records Labs select lab test ordering provider field is displayed]	
	126	5. The system shall capture appropriate order entry detail, including associated diagnosis.	Done	[select pt Medical Records Labs select lab test] The lab order detail is presented, including associated diagnosis.	Including associated diagnoses. It is desirable that all information for medical necessity checking be captured.
	128	7. The system shall relay orders for a diagnostic test to the correct destination for completion.	Done	[select pt Medical Records Labs select lab test view, print, or transmit requisition]	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.
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.					
	136	1. The system shall indicate normal and abnormal results based on data provided from the original data source.	Done	HL7 data is presented for lab results. PTP will indicate normal and abnormal results for "active" lab results. See John Doe example. Only "active" lab results are displayed in Medical Summary.	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.
	138	3. The system shall display non-numeric current and historical test results as textual data.	Done	[select pt Medical Records Lab Results click on Lab Results tab] Data is displayed as text.	
	146	11. The system shall provide the ability for a user to whom a result is presented to acknowledge the result.	Done	Method one: [select pt Medical Records Lab Results click Acknowledgement button]; Method two: [select Doctor or Nurse In-box select Lab Results tab click Acknowledgement button]	This is separate from audit trail.
Manage consents and authorizations: Create, maintain, and verify patient treatment decisions in the form of consents and authorizations when required.					

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	147	1. The system shall capture scanned paper consent documents (covered in DC 1.1.7).	Done	[select pt HIPAA select HIPAA Consent Forms tab click Documents scan document (use selection on left hand side, and make sure you enter "HIPAA" as document Category)]	
Manage patient advance directives: Capture, maintain, and provide access to patient advance directives.					
	152	1. The system shall provide the ability to indicate that a patient has completed advanced directive(s).	Done	[select pt record Medical Records More Details tab browse for Adv Directive or Living Will]	Important for appropriate use of resources at end of life and may just include a yes, no indication
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.					
	155	1. The system shall 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.	Done	Treatment Plans must be setup before use. [Other Treatment Plans add or edit]; to use plans, [select pt Medical Records]; TP's are presented in window at top right. Click on tile to access/toggle Preventive Plans. Double click plan to pull a checklist. Approve plan by selecting #4 in bottom menu.	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.
	156	2. The system shall provide the ability to create sitespecific care plan, protocol, and guideline documents.	Done	Treatment plans are user defined. [Other Treatment Plans add or edit]	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.
Support for drug interaction: Identify drug interaction warnings at the point of medication ordering					
	160	1. The system shall 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.	Done	[select pt Medical Records add medication] PTP will automatically check for drug-drug interaction, and advise user.	This reduces risk of inappropriate prescribing, prevents pharmacy call backs, and can reduce malpractice liability.

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	161	2. The system shall 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.	Done	[select pt Medical Records add medication] PTP will automatically check for drug-allergy interaction, and advise user.	
	162	3. The system shall provide the ability to prescribe a medication despite alerts for interactions and/or allergies being present.	Done	[select pt Medical Records add medication] PTP will automatically check for interactions and advise user. User can over-ride interactions if the interaction is not flagged as fatal.	
	163	4. The system shall provide the ability to set the severity level at which drug interaction warnings should be displayed.	Done	Severity levels can be set in the formulary: [Medical Formulary select the medication edit click the Drug - Drug Interaction tab add the interaction, and set the severity]; You must set the severity threshold in Quick Setup, page 11.	
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 byproduct 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.					
	173	1. The system shall provide the ability to document medication administration.	Done	[select pt Medical Records Medications select med Add Administration tab]	

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	174	2. The system shall provide the ability to document immunization administration.	Done	[select pt Medical Records Check Shots select shots or click Order edit will show administration details]	
Present alerts for disease management, preventive services and wellness: At the point of clinical decision making, identify patient specific suggestions/reminders, screening tests/exams, and other preventive services in support of disease management, routine preventive and wellness patient care standards.					
	180	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).	Done	Preventive Treatment Plans must be setup first. To use, [select pt Medical Records click the Treatment Plan tile select Preventive Treatment Plan by double clicking] Preventive Treatment Plans filter on patient age and sex.	This includes the use of clinical trial protocols to ensure compliance.
	181	2. The system shall display alerts based on established guidelines.	Done	Shot Calculator; [select pt Medical Records Check shots]	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).	Done	Treatment Plans; [select pt Medical Records select Treatment Plan in Find box]	Lab results in future years
	183	4. The system shall provide the ability to update disease management guidelines and associated reference material.	Done	From PTP desktop select [Other Treatment Plans add or edit Treatment Plan]; the Evidence Based Medicine (EBM) utility can also be used.	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.	Done	From PTP desktop select [Other Treatment Plans add or edit Treatment Plan]	

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	185	6. The system shall provide the ability to override guidelines.	Done	[select pt Medical Records select Treatment Plan and/or Preventive Treatment Plan select or de-select items presented]	
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.					
	190	1. The system shall identify preventive services, tests, or counseling that are due on an individual patient.	Done	Preventative Treatment Plans must be configured first. To use, [select pt Medical Records add or edit medical note click on the Treatment Plan tile to toggle the Preventive Treatment Plan that are appropriate]. Preventative Treatment Plans are based on pt date of birth and gender.	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 display reminders for disease management, preventive, and wellness services in the patient record.	Done	For auto Shot Calculator notification, check Peds in Quick Setup (page 2); to use [select pt Medical Records Check Shots]	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).	Done	For auto Shot Calculator notification, check Peds in Quick Setup (page 2); to use [select pt Medical Records Check Shots]	
	194	5. The system shall provide the ability to modify the guidelines that trigger the reminders.	Done	[Other Treatment Plans select and edit]	
	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.	Done	For auto Shot Calculator notification, check Peds in Quick Setup (page 2); to use [select pt Medical Records Check Shots]; PTP will display "Shots Recommended" or "Up to date" in medical record summary (peds only), otherwise you must click Check Shots for recommendation.	

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	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.	Done	[Medical Pt Immunization Missing Reset Prepare Report Print Report]	
Clinical task assignment and routing: Assignment, delegation and/or transmission of tasks to the appropriate parties.					
	198	1. The system shall provide the ability to create and assign tasks by user or user role.	Done	Setup User Groups: [Utilities Employees Employee Utilities <password> add User Groups and assign group numbers]; Edit each employee and assign to a user group: [GenAcct Employees tab select and edit Access tab assign to user group by double clicking]; when entering a message, you can "send to" user group]; messages can be viewed from the appointment calendar page.	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.
	201	4. The system shall provide the ability to designate a task as completed.	Done	[select pt Medical Records select Add Checklist add checklist] To indicate that a task is complete, just check the box	
	202	5. The system shall provide the ability to remove a task without completing the task.	Done	[select pt Medical Records select Add Checklist add checklist] To remove item from checklist [select an item right click click Delete]	Removing a task eliminates it from an individual user's "to do" list, not from audit logs, etc.
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.					

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	204	1. The system shall provide the ability to document verbal/telephone communication into the patient record.	Done	From PTP desktop, select [Messages]; from within patient record, select [Notes tab Messages]	
	205	2. The system shall provide the ability to incorporate paper documents from external providers into the patient record.	Done	[select Documents from with the pt record or from Medical Records]; from within patient record, select [Notes tab Messages]; enter message and select recipient; a small email icon will appear on desktop indicating that a message is waiting for user.	
	206	3. The system shall support messaging between users.	Done	From PTP desktop, select [Messages]; when a message is waiting for the user that is logged in, a small email icon will appear on the desktop in the left hand corner.	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.
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.					
	207	1. The system shall provide electronic communication between prescribers and pharmacies or other intended recipients of the medication order.	Done	You must first setup Faxing from Utilities [Utilities Quick Setup Page 3] [Then, from the pt's Medical Record, select a pharmacy and enter a fax number] [select a medication check FAX click Rx you will be prompted to fax]	Until electronic standards are established, FAX is a suitable means of transmission.
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.					
	210	1. The system shall maintain a directory of all clinical personnel who currently use or access the system.	Done	[ptp desktop select GenAcct Employees tab add or edit]	

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	211	2. The system shall 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.	Done	[ptp desktop select Other Doctors add or edit]	This directory may be the same as that in criteria #1 for this functionality.
	212	3. The system shall maintain a directory that stores user attributes required to determine the system security level to be granted to each user.	Done	[ptp desktop select GenAcct Employees tab add or edit Access tab]	This directory may be the same as that in criteria #1 for this functionality.
	213	4. The system shall allow authorized users to update the directory.	Done	[ptp desktop select GenAcct Employees tab add or edit Access tab] [This utility is password protected]	
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.					
	215	1. The system shall display a schedule of patient appointments, populated either through data entry in the system itself or through an external application interoperating with the system.	Done	[from ptp desktop, select Appointment button] [from pt record, select Appt tab]	
Report Generation: Provide report generation features for the generation of standard and ad hoc reports					
	216	1. The system shall provide the ability to generate reports of clinical and administrative data using either internal or external reporting tools.		Quick Setup, page 12 enter description for diagnosis data collection. [select pt Medical Records Diagnoses select dx edit enter data collection info]; click Print to prepare report.	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).	Done	[select pt Medical Records CCR select parts of pt's medical record to include Print]	Report format may be plain text.

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	220	5. The system shall provide the ability to access reports outside the EHR application.	Done	PTP generates pdf's for pt notes and reports. This can be access from outside of PTP.	For example, printed output, export to a file, etc.
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.					
	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.	Done	[select pt Medical Records CCR]	This could include but is not limited to the ability to generate standardized reports needed for work, school, or athletic participation.
	228	5. The system shall create hardcopy and electronic report summary information (procedures, medications, labs, immunizations, allergies, and vital signs).	Done	[select pt Medical Records click Print at top of screen]	The report that's produced should be organized by section to make it easier to read.
	229	6. The system shall provide support for disclosure management in compliance with HIPAA and applicable law.	Done	[select pt record click HIPAA]	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.
Encounter management: Manage and document the health care delivered during an encounter.					
	230	1. The system shall provide the ability to document a patient encounter.	Done	[select pt Medical Records Add Note or Prepare eTicket]	
	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.	Done	[select pt Medical Records Add Note or Prepare eTicket]	This does not preclude entry via new technologies.

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	232	3. The system shall provide the ability to associate individual encounters with diagnoses.	Done	[select pt enter medical diagnoses prepare eTicket] [You can enter associate dx with each transaction]	
Rules-driven financial and administrative coding assistance: Provide financial and administrative coding assistance based on the structured data available in the encounter documentation.					
	234	1. The system shall provide a list of financial and administrative codes.	Done	[ptp manages icd-9 codes (diagnoses) and CPT codes (procedure codes)] [from desktop, select Other Diagnoses or Procedure Codes]	For example, ICD-9 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.	Done	[select pt Medical Records add or edit note select Chk tab select the type of encounter enter the level of service for Exam, History, and Medical Decision Making click Check Docs the appropriate CPT code will be displayed]]	May be accomplished via a link to another application.
Manage Practitioner/Patient S.3.4 relationships: Identify relationships among providers treating a single patient, and provide the ability to manage patient lists assigned to a particular provider.					
	240	1. The system shall identify by name all providers associated with a specific patient encounter.	Done	[select pt Medical Records select medical note provider id is located on chk tab]	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.
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					

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	244	1. The system shall provide the ability to update the clinical content or rules utilized to generate clinical decision support reminders and alerts.	Done	Utility to update growth charts: [Utilities Medical Records Utilities Setup Pediatric Forms Page 7 select Range, low and high percentials click Populate]. These values will be presented when entering vitals for a pediatric patient. Utility to update drug interactions: [Medical Formulary slect and edit medication select Drug - Drug tab add or remove interactions]	Growth charts, CPT-4 codes, drug interactions would be an example. Any method of updating would be acceptable. Content could be third part or customer created. /Any method of updating would be
	245	2. The system shall provide the ability to update clinical decision support guidelines and associated reference material.	Done	[EBM] You can update reference material for medication and diagnoses literature.	Any method of updating would be acceptable. Content could be third part or customer created.
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.					
	252	1. The system shall retain data until otherwise purged, deleted, archived or otherwise deliberately removed.	Done	PTP does not delete info unless specifically directed to do so by the user.	

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
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.					
	257	1. The system shall provide the ability to export (extract) pre-defined set(s) of data out of the system	Done	Method one: [ptp desktop Medical Health Department select report to prepare] Method two: Use Data Architech to query databases	For example, export of performance measures, ability to query data base, chronic disease management tools.
Concurrent Use: EHR system supports multiple concurrent physicians through application, OS and database.					
	261	1. The system shall provide the ability for multiple users to interact concurrently with the EHR application.	Done	This is demonstrated in multi-user environment. Advantage Database Server is required. Launch two instances of PTP	
	262	2. The system shall provide the ability for concurrent users to simultaneously view the same record.	Done	This is demonstrated in multi-user environment. Advantage Database Server (ADS) is required. Launch two instances of PTP. Access the same record. ADS allows multiple user to access the same record. Only one user can modify the record at a time. All record locking is done by ADS. Please note that a "data" record is not the same as a patient "record".	

Category and Description	Original line # Phase I	Specific Criteria	Status	Access	Discussion / Comments
	263	3. The system shall provide the ability for concurrent users to view the same clinical documentation or template.	Done	This is demonstrated in multi-user environment. Advantage Database Server (ADS) is required. Launch two instances of PTP. Access the same record. ADS allows multiple user to access the same record. Only one user can modify the record at a time. All record locking is done by ADS.	
	264	4. The system shall provide record level protection to maintain the integrity of clinical data.	Done	This is demonstrated in multi-user environment. Advantage Database Server (ADS) is required. Launch two instances of PTP. Access the same record. ADS allows multiple user to access the same record. Only one user can modify the record at a time. All record locking is done by ADS.	To prevent users from simultaneously attempting to update a record with resultant loss of data