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DC.1	**H**	**EN**	**Care Management**	**Description:** Care Management functions (i.e., DC.1.x functions) are those directly used by providers as they deliver patient care and create an electronic health record. DC.1.1.x functions address the mechanics of creating a health record and concepts such as a single logical health record, managing patient demographics, and managing externally generated (including patient originated) health data. Thereafter, functions DC.1.2.x through DC.1.9.x follow a fairly typical flow of patient care activities and corresponding data, starting with managing the patient history and progressing through consents, assessments, care plans, orders, results, etc. Integral to these care management activities is an underlying system foundation that maintains the privacy, security, and integrity of the captured health information -- the information infrastructure of the EHR-S. Throughout the DC functions, conformance criteria formalize the relationships to Information Infrastructure functions. Criteria that apply to all DC.1 functions are listed in this header (see Conformance Clause page six for discussion of "inherited" conformance criteria). In the Direct Care functions there are times when actions/activities related to "patients" are also applicable to the patient representative. Therefore, in this section, the term "patient" could refer to the patient and/or the patient's personal representative (e.g., guardian, surrogate).		1. The system **SHALL** conform to function IN.1.1 (Entity Authentication).	1	DC.1	1	N/C
						2. The system **SHALL** conform to function IN.1.2 (Entity Authorization).	2	DC.1	2	N/C
						3. The system **SHALL** conform to function IN.1.3 (Entity Access Control).	3	DC.1	3	N/C
						4. IF the system is used to enter, modify or exchange data, THEN the system **SHALL** conform to function IN.1.5 (Non-Repudiation), to guarantee that the sources and receivers of data cannot deny that they entered/sent/received the data.	4	DC.1	4	N/C
						5. IF the system exchanges data outside of a secure network, THEN the system **SHALL** conform to Function IN.1.6 (Secure Data Exchange), to ensure that the data are protected.	5	DC.1	5	N/C
						6. IF the system exchanges data outside of a secure network, THEN the system **SHALL** conform to Function IN.1.~~7~~ 10 (Secure Data Routing -LTC), to ensure that the exchange occurs only among authorized senders and receivers.	6	DC.1	6	M
						7. IF the system is used to enter or modify data in the health record, THEN the system **SHALL** conform to function IN.1.8 (Information Attestation), to show authorship and responsibility for the data.	7	DC.1	7	N/C

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						8. The system **SHALL** conform to function IN.1.9 (Patient Privacy and Confidentiality).	8	DC.1	8	N/C
						9. The system **SHALL** conform to function IN.2.1 (Data Retention, Availability and Destruction).	9	DC.1	9	N/C
						10. The system **SHOULD** conform to function IN.2.3 (Synchronization).	10	DC.1	10	N/C
						11. IF the system is used to extract data for analysis and reporting, THEN the system **SHALL** conform to function IN.2.4 (Extraction of Health Record Information), to support data extraction across the complete health record of an individual.	11	DC.1	11	N/C
						12. IF the system stores unstructured data, THEN the system **SHALL** conform to function IN.2.5.1 (Manage Unstructured Health Record Information), to ensure data integrity through all changes.	12	DC.1	12	N/C
						13. IF the system stores structured data, THEN the system SHALL conform to function IN.2.5.2 (Manage Structured Health Record Information), to ensure data integrity through all changes.	13	DC.1	13	N/C
						14. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	14	DC.1	14	N/C
						15. IF the system processes data for which generally accepted standard terminologies have been established, THEN the system **SHALL** conform to function IN.4.1 (Standard Terminologies and Terminology Models), to support semantic interoperability.	15	DC.1	15	N/C

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						16. IF the system processes data for which generally accepted standard terminologies have been established, THEN the system **SHALL** conform to function IN.4.2 (Maintenance and Versioning of Standard Terminologies), to preserve the semantics of coded data over time.	16	DC.1	16	N/C
						17. The system **SHOULD** conform to function IN.4.3 (Terminology Mapping).	17	DC.1	17	N/C
						18. IF the system exchanges data for which generally accepted interchange standards have been established, THEN the system **SHALL** conform to function IN.5.1 (Interchange Standards), to support interoperability.	18	DC.1	18	N/C
						19. IF the system exchanges data for which generally accepted interchange standards have been established, THEN the system **SHALL** conform to function IN.5.2 (Interchange Standards Versioning and Maintenance), to accommodate the inevitable evolution of interchange standards.	19	DC.1	19	N/C
						20. The system **SHOULD** conform to function IN.5.3 (Standards-based Application Integration).	20	DC.1	20	N/C
						21. IF the system exchanges data with other systems outside itself, THEN the system **SHALL** conform to function IN.5.4 (Interchange Agreements), to define how the sender and receiver will exchange data.	21	DC.1	21	N/C
						22. The system **SHOULD** conform to function IN.6 (Business Rules Management).	22	DC.1	22	N/C

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						23. The system **SHOULD** conform to function IN.7 (Workflow Management).	23	DC.1	23	N/C
						24. The system **SHALL** conform to function S.2.2.1 (Health Record Output).	24	DC.1	24	N/C
DC.1.1	**H**	**EN**	Record Management	**Statement**: **Description**: For those functions related to data capture, data may be captured using standardized code sets or nomenclature, depending on the nature of the data, or captured as unstructured data. ~~Care-setting dependent~~ Data is entered by a variety of caregivers. Details of who entered data and when it was captured should be tracked. Data may also be captured from devices or other tele-health applications.	S.3.1.4		25	DC.1.1		M
DC.1.1.1	**F**	**EN**	Identify and Maintain a Patient Record	**Statement**: Identify and maintain a single patient record for each patient. **Description**: A single record is needed for legal purposes, as well as to organize it unambiguously for the provider. Health information is captured and linked to the patient record. Static data elements as well as data elements that will change over time are maintained. The patient is uniquely identified, after which the record is tied to that patient. Combining information on the same patient, or separating information where it was inadvertently captured for the wrong patient, ~~helps~~ maintains health information for a single patient. In the	S.1.4.1 S.2.2.1 S.3.1.2 S.3.1.5 IN.2.1 IN.2.3	1. The system **SHALL** create a single logical record for each patient.	26	DC.1.1.1	1	N/C
						2. The system **SHALL** provide the ability to create a record for a patient when the identity of the patient is unknown.	27	DC.1.1.1	2	N/C
						3. The system **SHALL** provide the ability to store more than one identifier for each patient record.	28	DC.1.1.1	3	N/C
						4. The system **SHALL** associate key identifier information (e.g., system ID, medical record number) with each patient record.	29	DC.1.1.1	4	N/C
						5. The system **SHALL** provide the ability to uniquely identify a patient and tie the record to a single patient.	30	DC.1.1.1	5	N/C

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				process of creating a patient record, it is at times advantageous to replicate identical information across multiple records, so that such data does not have to be re-entered. ~~For example, when a parent registers children as new patients, the address, guarantor, and insurance data may be propagated in the children's records without having to re-enter them~~. For example, when a couple (i.e., husband and wife) are registered as new patients, the address, guarantor, and insurance data may be propagated from the record of one spouse to the other without having to re-enter the data.		6. The system **SHALL** provide the ability, through a controlled method, to merge or link dispersed information for an individual patient upon recognizing the identity of the patient.	31	DC.1.1.1	6	N/C
						7. IF health information has been mistakenly associated with a patient, THEN the system **SHALL** provide the ability to mark the information as erroneous in the record of the patient in which it was mistakenly associated and represent that information as erroneous in all outputs containing that information.	32	DC.1.1.1	7	N/C
						8. IF health information has been mistakenly associated with a patient, THEN the system **SHALL** provide the ability to associate it with the correct patient.	33	DC.1.1.1	8	N/C
						9. The system **SHALL** provide the ability to retrieve parts of a patient record using a primary identifier, secondary identifiers, or other information which are not identifiers, but could be used to help identify the patient.	34	DC.1.1.1	9	N/C
						10. The system ~~**SHOULD**~~ **SHALL** provide the ability to obsolete, inactivate, nullify, destroy and archive a patient's record in accordance with local policies and procedures, as well as applicable laws and regulations.	35	DC.1.1.1	10	M
						11. IF related patients register with any identical data, THEN the system ~~**SHOULD**~~ **MAY** provide the ability to propagate that data to all their records.	36	DC.1.1.1	11	M

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						12. The system **SHALL** conform to function IN.2.2 (Auditable Records).	37	DC.1.1.1	12	N/C
DC.1.1.2	**F**	**EN**	Manage Patient Demographics	**Statement**: Capture and maintain demographic information. Where appropriate, the data should be clinically relevant and reportable. **Description**: Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, time of birth, gestation, gender, and other information is stored and maintained for unique patient identification, reporting purposes and for the provision of care. Patient demographics are captured and maintained as discrete fields (e.g., patient names and addresses) and may be enumerated, numeric or codified. Key patient identifiers are shown on all patient information output (such as name and ID# on each screen of a patient's record). The system will track who updates demographic information, and when the demographic information is updated.	S.1.4.1 S.2.2.2 IN.2.2 IN.2.4	1. The system **SHALL** capture demographic information as part of the patient record.	38	DC.1.1.2	1	N/C
						2. The system **SHALL** store and retrieve demographic information as discrete data.	39	DC.1.1.2	2	N/C
						3. The system **SHALL** provide the ability to retrieve demographic data as part of the patient record.	40	DC.1.1.2	3	N/C
						4. The system **SHALL** provide the ability to update demographic data.	41	DC.1.1.2	4	N/C
						5. The system ~~**SHOULD**~~ **SHALL** provide the ability to report demographic data.	42	DC.1.1.2	5	M
						6. The system ~~**SHOULD**~~ **SHALL** store historical values of demographic data over time.	43	DC.1.1.2	6	M
						7. The system **SHALL** present a set of patient identifying information at each interaction with the patient record.	44	DC.1.1.2	7	N/C
						8. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	45	DC.1.1.2	8	N/C
						9. The system **SHALL** conform to function IN.2.2 (Auditable Records).	46	DC.1.1.2	9	N/C
DC.1.1.3	**H**	**EN**	Data and Documentation from External Sources	**Description**: External sources are those outside the EHR system, including clinical, administrative, and financial information systems, other EHR systems, PHR systems, and data received through health information exchange networks.		1. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	47	DC.1.1.3	1	N/C
						2. The system **SHALL** conform to function IN.2.2 (Auditable Records).	48	DC.1.1.3	2	N/C
DC.1.1.3.1	**F**	**EN**	Capture Data and Documentation from External Clinical Sources	**Statement**: Incorporate clinical data and documentation from external sources.	IN.1.5 IN.1.6	1. The system **SHALL** provide the ability to capture external data and documentation.	49	DC.1.1.3.1	1	N/C

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				Description: Mechanisms are available for capturing and incorporating external clinical data and documentation ~~(including identification of source) such as image documents and other clinically relevant data are available~~. This covers all types of data and documents received by the nursing facility that would typically be incorporated into a medical record, including but not limited to faxes, referral authorizations, consultant reports, and patient/resident correspondence of a clinical nature. (cc#1) Intrinsic to the concept of electronic health records is the ability to exchange health information with other providers of health care services. Health information from these external sources needs to be received, stored in the patient record, and displayed upon request. External data and documents addressed in the function include: 1. Lab results received through an electronic interface -- This information is to be received and stored in the resident record as discrete data, which means that each separate element of the data needs to be stored in is own field. Therefore, if lab results are received through an electronic interface, the results are received in the EHR and the lab test name, result (value), and unit of measure are correctly displayed as discrete data (vs. report format). (cc#2 & #3) 2. Scanned documents received and stored as images (i.e. power of	IN.1.7 IN.1.8 IN.2.1 IN.2.2 IN.4.2 IN.4.3 IN.5.1 IN.5.2	2. IF lab results are received through an electronic interface, THEN the system **SHALL** receive and store the data elements into the patient record.	50	DC.1.1.3.1	2	N/C
						3. IF lab results are received through an electronic interface, THEN the system **SHALL** display them upon request.	51	DC.1.1.3.1	3	N/C
						4. The system ~~**SHOULD**~~ **SHALL** provide the ability to receive, store and display scanned documents as images.	52	DC.1.1.3.1	4	M
						4a. The system **SHALL** provide the ability to index and retrieve scanned documents as images based on the document type, the date of the original document and the date of scanning	53	DC.1.1.3.1		A
						5. The system **MAY** provide the ability to store imaged documents or reference the imaged documents via links to imaging systems.	54	DC.1.1.3.1	5	N/C
						6. The system **SHOULD** provide the ability to receive, store and present text-based externally-sourced documents and reports.	55	DC.1.1.3.1	6	N/C
						7. The system **SHOULD** provide the ability to receive, store and display clinical result images (such as radiologic images) received from an external source.	56	DC.1.1.3.1	7	N/C
						8. The system **SHOULD** provide the ability to receive, store and display other forms of clinical results (such as wave files of EKG tracings) received from an external source.	57	DC.1.1.3.1	8	N/C
						9. The system ~~**SHOULD**~~ **SHALL** provide the ability to receive, store and present medication details from an external source.	58	DC.1.1.3.1	9	M

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				attorney forms, Living wills, etc.) -- These scanned documents are indexed and can be retrieved based on the document type, date of the original document, and the date of scanning. (cc#4 & cc#4a) 3. Text-based outside reports (i.e., x-ray reports, hospital discharge summaries, history & physicals) -- Any mechanism for capturing these reports is acceptable: OCR, PDF, image file of report, etc. (cc#6) 4. Clinical images from an external source (i.e., radiographic images, digital images from a diagnostic scan or graphical images) -- These images may be stored within the system or be provided through direct linkage to an external source such as a hospital PACS system. (cc#7) 5. Other forms of clinical results, such as wave files of EKG tracings (cc#8) 6. Medication detail (i.e., a medication history) from an external source such as a retail pharmacy, the patient, or another provider -- While the medication detail includes the medication name, strength, and SIG, this does not imply that the data will populate the medication module. (cc#9) 7. Structured, text-based reports (such as medical summary text in a structured format) (cc#10)		10. The system **SHOULD** provide the ability to receive, store and present structured text-based reports received from an external source.	59	DC.1.1.3.1	10	N/C
						11. The system **SHOULD** provide the ability to receive, store and present standards-based structured, codified data received from an external source.	60	DC.1.1.3.1	11	N/C

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				8. Standards-based structured, codified data (such as a Continuity of Care Record with SNOMED CT) (cc#11) Data incorporated through these mechanisms is presented alongside locally captured documentation and notes wherever appropriate.						
DC.1.1.3.2	**F**	**EF 2010**	Capture Patient-Originated Data	**Statement**: Capture and explicitly label patient-originated data, link the data source with the data, and support provider authentication for inclusion in patient health record. **Description**: It is critically important to be able to distinguish clinically authored and authenticated data from patient-originated data that is either provided by the patient for inclusion in the EHR or entered directly into the EHR by the patient ~~from clinically authenticated data. Patients may provide data for entry into the health record or be given a mechanism for entering this data directly~~. Patient-originated data intended for use by providers will be available for their use. Data about the patient may be appropriately provided by:	IN.1.4 IN.2.5.1 IN.2.5.2	1. The system **SHALL** capture and explicitly label patient- originated data.	61	DC.1.1.3.2	1	N/C
						1a. The system **SHALL** provide the ability to capture patient originated data including, but not limited to, demographics, past medical history, medications, and allergies.	62			A
						2. IF the system provides the ability for direct entry by the patient, THEN the system **SHALL** explicitly label the data as patient entered.	63	DC.1.1.3.2	2	N/C
						3. The system **SHALL** capture and label the source of clinical data provided on behalf of the patient.	64	DC.1.1.3.2	3	N/C
						4. The system **SHALL** present patient-originated data for use by care providers.	65	DC.1.1.3.2	4	N/C
						5. The system **SHALL** provide the ability for a provider to ~~verify~~ indicate they have verified the accuracy of patient-originated data (when appropriate and when a verification source is available) for inclusion in the patient record.	66	DC.1.1.3.2	5	M

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				1. the patient 2. a surrogate (parent, spouse, guardian) or 3. an informant (teacher, lawyer, case worker). An electronic health record may provide the ability for direct data entry by any of these. Patient-originated data may also be captured by devices and transmitted for inclusion into the electronic health record. Data entered by any of these must be stored with source information. ~~A provider must authenticate patient-originated data included in the patient's legal health record~~. A provider must be able to indicate they have verified the accuracy of patient-originated data (when appropriate and when a verification source is available) for inclusion in the patient record. Such verification does not have to occur at each individual data field and can be at a higher level of the data.		6. The system ~~**SHOULD**~~ **SHALL** provide the ability to view ~~or~~ and comment, but not alter patient-originated data.	67	DC.1.1.3.2	6	M
DC.1.1.3.3	**F**	**EN**	Capture Patient Health Data Derived from Administrative and Financial Data and Documentation	**Statement**: Capture and explicitly label patient health data derived from administrative or financial data; and link the data source with that data. **Description**: It is critically important to be able to distinguish patient health data derived from administrative or financial data from clinically authenticated data. Sources of administrative and financial data relating to a patient's health may provide this data for entry into the health record or be given a mechanism for	DC.1.1.2 DC.1.2 S.1.4.1	1. The system **SHALL** provide the ability to capture and label patient health data derived from administrative or financial data.	68	DC.1.1.3.3	1	N/C
						2. The system **SHALL** provide the ability to capture and link data about the source of patient health data derived from administrative and financial data with that patient data.	69	DC.1.1.3.3	2	N/C

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				entering this data directly. The data must be explicitly labeled as derived from administrative or financial data, and information about the source must be linked with that data. Patient health data that is derived from administrative or financial data may be provided by: 1. the patient 2. a provider 3. a payer, or 4. entities that transmit or process administrative or financial data. Since this data is non-clinical, it may not be authenticated for inclusion in the patient's legal health record. Registration data, which may contain demographic data and pertinent positive and negative histories, is an example of administrative and financial data that may be captured.		3. The system **SHALL** provide the ability to present labeled patient health information derived from administrative or financial data and the source of that data for use by authorized users.	70	DC.1.1.3.3	3	N/C
						4. The system **SHOULD** provide the ability to view health information data and ~~or~~ comment on patient health ~~information~~ records or documents derived from administrative or financial data.	71	DC.1.1.3.3	4	M
						4a. The system **SHALL** provide the ability to correct administrative and financial data.	72			A
						5. The system **SHOULD** provide the ability to request correction from the external source of the administrative or financial data.	73	DC.1.1.3.3	5	M
DC.1.1.4	**F**	**EN**	Produce a Summary Record of Care	**Statement**: Present a summarized review of a patient's comprehensive EHR, subject to jurisdictional laws and organizational policies related to privacy and confidentiality. **Description**: Create summary views and reports at the conclusion of an episode of care. Summarized views and reports of the episode of care must support requirements in the CMS State Operations Manual for a discharge summary and should support other secondary uses of information such as	S.2.2.1 IN.1.9 IN.2.4 IN.2.5.1 IN.2.5.2	1. The system **SHALL** present summarized views and reports of the patient's comprehensive EHR, including, but not limited to, discharge summary requirements as stated in the CMS State Operations Manual.	74	DC.1.1.4	1	M
						2. ~~The system **SHOULD** include at least the following in the summary: problem list, medication list, allergy and adverse reaction list.~~	75	DC.1.1.4	2	D
						2a. The system **SHALL** create an HL7 compliant Continuity of Care Document (CCD).	76			A

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				public health reporting. In addition, summarized health information must be produced as an HL7 compliant Continuity of Care Document (CCD) in order to support interoperable exchange of health information with other care providers. Output of the CCD should be supported in electronic and paper formats. At a minimum, the CCD must contain content for the Advance Directives, Problems, Alerts, and Medications sections. • The Advance Directives section of the CCD contains data defining the patient's advance directives and any reference to supporting documentation. The most recent and up-to-date directives are required, if known, and should be listed in as much detail as possible. This section contains data such as the existence of living wills, healthcare proxies, and CPR and resuscitation status. If referenced documents are available, they can be included in the CCD exchange package. • The "Problems" section of the CCD lists and describes all relevant clinical problems at the time the summary is generated. At a minimum, all pertinent current and historical problems should be listed. • The "Alerts" section of the CCD is used to list and describe any allergies, adverse reactions, and alerts that are pertinent to the patient's current or past medical history. At a minimum, currently		2b. The system **SHALL** provide the ability to produce a CCD that includes at least the following sections: Advance Directives, Problems, Alerts, and Medications.	77			A
						2c. The system **SHOULD** provide the ability to produce a CCD that includes the following sections: Functional Status, Immunizations, Medical Equipment and Plan of Care.	78			A
						2d. The system **SHOULD** provide the ability to populate the following sections of an HL7 compliant CCD without requiring additional input from clinicians: Advance Directives, Problems, Alerts, and Medications.	79			A
						2e. IF federally mandated assessments are included in the Functional Status section of the CCD, THEN those assessments **SHOULD** comply with NCVHS/CHI endorsed standards for the representation of the assessment and vocabulary content.	80			A
						3. The system **SHOULD** conform to function S.3.3.6 (Health Service Reports at the Conclusion of an Episode of Care).	81	DC.1.1.4	3	N/C
						4. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	82	DC.1.1.4	4	N/C
						5. The system **SHALL** conform to function IN.2.2 (Auditable Records).	83	DC.1.1.4	5	N/C

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				active and any relevant historical allergies and adverse reactions should be listed. • The "Medications" section of the CCD defines a patient's current medications and pertinent medication history. At a minimum, the currently active medications should be listed, with an entire medication history as an option, particularly when the summary document is used for comprehensive data export. The section may also include a patient's prescription history, and enables the determination of the source of a medication list (e.g., from a pharmacy system vs. from the patient). It is strongly recommended that the CCD contain content for the Functional Status, Immunizations, Medical Equipment, and Plan of Care sections. ~~Create~~ Service reports created at the completion of an episode of care such as, ~~but not limited to~~, discharge summaries and public health reports, should be compiled without requiring additional input from clinicians.						
DC.1.1.5	**F**	**EN**	Present Ad Hoc Views of the Health Record	**Statement**: Subject to jurisdictional laws and organizational policies related to privacy and confidentiality, present customized views and summarized information from a patient's comprehensive EHR. The view may be arranged chronologically, by problem, or other parameters, and may be filtered or sorted.	S.1.8 S.2.2.3 S.3.1.1 IN.1.3 IN.1.6 IN.1.7	1. The system **SHALL** provide the ability to create views that prohibit patients from accessing certain information according to organizational policy, scope of practice, and jurisdictional law.	84	DC.1.1.5	1	N/C

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				Description: A key feature of an electronic health record is its ability to support the delivery of care by enabling prior information to be found and meaningfully displayed. EHR systems should facilitate search, filtering, summarization, and presentation of available data needed for patient care. Systems should enable views to be customized, for example, specific data may be organized chronologically, by clinical category, ~~or~~ by consultant, or by discipline, depending on need. Jurisdictional laws and organizational policies that prohibit certain users from accessing certain patient information must be supported.	IN.1.9 IN.2.4 IN.2.5.1 IN.2.5.2 IN.4.1 IN.4.2 IN.4.3 IN.5.1 IN.5.2 IN.5.4 IN.6	2. The system ~~**SHOULD**~~ **SHALL** provide the ability to create customized views of summarized information based on sort and filter controls for date or date range, problem, or other clinical parameters.	85	DC.1.1.5	2	M
						3. The system ~~**SHOULD**~~ **SHALL** provide the ability to access summarized information through customized views based on prioritization of chronology, problem, or other pertinent clinical parameters.	86	DC.1.1.5	3	M
						4. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	87	DC.1.1.5	4	N/C
						5. The system **SHALL** conform to function IN.2.2 (Auditable Records).	88	DC.1.1.5	5	N/C
DC.1.2	**F**	**EN**	Manage Patient History	**Statement**: Capture and maintain medical, procedural/surgical, social and family history including the capture of pertinent positive and negative histories, patient-reported or externally available patient clinical history. **Description**: The history of the current illness and patient historical data related to previous medical diagnoses, surgeries and other procedures performed on the patient, and relevant health conditions of family members is captured through such methods as patient reporting (for example interview, medical alert band) or electronic or non-electronic historical data. This data may take the form of a pertinent positive such as: "The patient/family member has had..." or a pertinent negative such as "The patient/family member has not had..." When first seen by a health care	S.2.2.1 S.3.5 IN.1.7 IN.2.5.1 IN.2.5.2 IN.4.1 IN.4.2 IN.4.3 IN.5.1 IN.5.2 IN.5.4	1. The system **SHALL** provide the ability to capture, update and present current patient history including pertinent positive and negative elements.	89	DC.1.2	1	N/C
						1a. The system **SHALL** provide the ability to capture structured data in the patient history.	90			A
						2. The system ~~**SHOULD**~~ **SHALL** provide the ability to capture and present previous external patient histories in compliance with Function DC.1.3.1.1 (Capture Data and Documentation from External Clinical Sources).	91	DC.1.2	2	M
						3. The system **MAY** provide the ability to capture the relationship between patient and others.	92	DC.1.2	3	N/C
						4. The system **SHALL** capture the complaint, presenting problem or other reason(s) for the visit or encounter.	93	DC.1.2	4	N/C

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				provider, patients typically bring with them clinical information from past encounters. This and similar information is captured and presented alongside locally captured documentation and notes wherever appropriate.		5. The system ~~**SHOULD**~~ **SHALL** provide the ability to capture the reason for visit/encounter from the patient's perspective.	94	DC.1.2	5	M
						6. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	95	DC.1.2	6	N/C
						7. The system **SHALL** conform to function IN.2.2 (Auditable Records).	96	DC.1.2	7	N/C
DC.1.3	**H**	**EN**	Preferences, Directives, Consents and Authorizations	**Description:** In the Preferences, Directives, Consents and Authorizations functions there are times when actions/activities related to "patients" are also applicable to the patient representative. Therefore, in this section, the term "patient" could refer to the patient and/or the patient's personal representative (i.e., guardian, surrogate, proxy, health care agent).		1. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	97	DC.1.3	1	N/C
						2. The system **SHALL** conform to function IN.2.2 (Auditable Records).	98	DC.1.3	2	N/C
DC.1.3.1	**F**	**EN**	Manage Patient and Family Preferences	**Statement**: Capture and maintain patient and family preferences. **Description**: Patient and family preferences regarding issues such as language, religion, spiritual practices and culture -- may be important to the delivery of care. It is important to capture these so that they will be available to the provider at the point of care.	DC.2.1.4 S.3.7.1 IN.2.5.1 IN.2.5.2 IN.6	1. The system **SHALL** provide the ability to capture, present, maintain and make available for clinical decisions patient preferences such as language, religion, spiritual ~~practices~~ and cultural practices.	99	DC.1.3.1	1	M
						2. The system **SHALL** provide the ability to capture, present, maintain and make available for clinical decisions family preferences such as language, religion, spiritual ~~practices~~ and cultural practices.	100	DC.1.3.1	2	M
						3. The system **SHOULD** conform to function DC.2.1.4 (Support for Patient and Family Preferences), and incorporate patient and family preferences into decision support systems.	101	DC.1.3.1	3	N/C
DC.1.3.2	**F**	**EN**	Manage Patient Advance Directives	**Statement**: Capture and maintain patient advance directives.	S.3.5.1 S.3.5.3	1. The system **SHALL** provide the ability to indicate that advance directives exist for the patient.	102	DC.1.3.2	1	N/C

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				Description: Patient advance directives and provider DNR orders are captured as well as the date and circumstances under which the directives were received, and the location of any paper records or legal documentation (e.g., the original) of advance directives as appropriate.	S.3.5.4 IN.1.5 IN.1.8 IN.1.9 IN.2.2 IN.2.5.1 IN.2.5.2 IN.6	2. The system **SHALL** provide the ability to indicate the type of advance directives completed for the patient such as living will, durable power of attorney, preferred interventions for known conditions, or the existence of a "Do Not Resuscitate order".	103	DC.1.3.2	2	N/C
						3. The system ~~**SHOULD**~~ **SHALL** provide the ability to capture, present, maintain and make available for clinical decisions patient advance directives documents and "Do Not Resuscitate" orders.	104	DC.1.3.2	3	M
						4. The system ~~**SHOULD**~~ **SHALL** conform to function DC.1.1.3.1 (Capture Data and Documentation from External Clinical Sources) and capture ~~scanned~~ patient advance directive documents and "Do Not Resuscitate" orders.	105	DC.1.3.2	4	M
						5. The system ~~**SHOULD**~~ **SHALL** provide the ability to indicate when advanced directives were last reviewed.	106	DC.1.3.2	5	M
						6. The system ~~**SHOULD**~~ **SHALL** provide the ability to indicate the name and relationship of the party completing the advance directive for the patient.	107	DC.1.3.2	6	M
						7. The system **SHALL** time and date stamp the entry of advance directives information.	108	DC.1.3.2	7	M
						7a. The system **SHOULD** provide the ability to capture the date and/or time a paper advance directives document was signed/completed.	109			A

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						7b. The system **SHOULD** provide the ability to capture the date and/or time advance directive information was received by the provider.	110			A
						8. The system ~~**SHOULD**~~ **SHALL** provide the ability to document the location and or source of any legal documentation regarding advance directives.	111	DC.1.3.2	8	M
						9. The system **SHOULD** conform to function DC.2.1.4 (Support for Patient and Family Preferences).	112	DC.1.3.2	9	N/C
DC.1.3.3	**F**	**EN**	Manage Consents and Authorizations	**Statement**: Create, maintain, and verify patient decisions such as informed consent for treatment and authorization/consent for disclosure when required. **Description**: Decisions are documented and include the extent of information, verification levels and exposition of treatment options. This documentation helps ensure that decisions made at the discretion of the patient, family, or other responsible party, govern the actual care that is delivered or withheld. There may be several documents active at any one time that may govern a patient's care. Both clinical and administrative consents and authorizations are considered part of this function. A consent or authorization includes patient authorization for re-disclosure of sensitive information to third parties.	DC.1.1.3 S.2.2.2 S.3.5.1 S.3.5.4 IN.1.5 IN.1.8 IN.1.9 IN.2.2 IN.2.4 IN.2.5.1 IN.2.5.2 IN.6	1. The system **SHALL** provide the ability to indicate that a patient has completed applicable consents and authorizations.	113	DC.1.3.3	1	N/C
						2. The system **SHALL** provide the ability to indicate that a patient has withdrawn applicable consents and authorizations.	114	DC.1.3.3	2	N/C
						3. The system ~~**SHOULD**~~ **SHALL** conform to function DC.1.1.3.1 (Capture Data and Documentation from External Clinical Sources) and capture scanned paper consent and authorization documents.	115	DC.1.3.3	3	M
						4. The system **SHOULD** provide the ability to view and complete consent and authorization forms ~~on-line~~ electronically.	116	DC.1.3.3	4	M
						4a. IF the system provides the ability to complete consents and authorizations electronically, THEN the system **SHALL** provide the ability for patients to electronically sign consent and authorization forms in conformance with IN.1.8 (Information Attestation).	117			A

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				Consents/Authorizations for printing should include appropriate standardized forms for patients, guardians, foster parents. ~~The system must appropriately present forms for adolescents according to privacy rules~~. Some states may mandate assent. Assent is agreement by the patient to participate in services when they are legally unable to consent (e.g., an adolescent, an adult with early dementia).		5. The system **MAY** provide the ability to generate printable consent and authorization ~~forms~~ form templates.	118	DC.1.3.3	5	M
						5a. IF the system allows completion of electronic authorizations and consents, THEN the system **SHALL** provide the ability to generate printable consent and authorization form templates.	119			A
						6. The system **MAY** display the consents and authorizations associated with a specific clinical activity, such as treatment (e.g., immunizations) or surgery (e.g., wound debridement), along with that event in the patient's electronic chart.	120	DC.1.3.3	6	M
						7. The system ~~**MAY**~~ **SHALL** provide the ability to sort and display consents and authorizations chronologically, reverse chronologically, and by type.	121	DC.1.3.3	7	M
						8. The system ~~**SHOULD**~~ **MAY** provide the ability to document an assent for patients legally unable to consent.	122	DC.1.3.3	8	M
						9. IF the system provides the ability to complete consents and authorizations electronically, THEN the system **SHALL** provide the ability to document the source of each consent and authorization, such as the patient or the patient's personal representative if the patient is legally unable to provide it.	123	DC.1.3.3	9	M

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						10. IF the system provides the ability to complete consents and authorizations electronically, THEN the system ~~**SHOULD**~~ **SHALL** provide the ability to document the patient's personal representative's level of authority to make decisions on behalf of the patient.	124	DC.1.3.3	10	M
DC.1.4	**H**	**EN**	Summary Lists	Summary lists are used to present succinct "snapshots" of critical health information such as allergy, medication, problem, and immunization lists.	S.2.2.2 IN.2.4 IN.2.5.1 IN.2.5.2	1. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	125	DC.1.4	1	N/C
						2. The system **SHALL** conform to function IN.2.2 (Auditable Records).	126	DC.1.4	2	N/C
DC.1.4.1	**F**	**EN**	Manage Allergy, Intolerance and Adverse Reaction List	**Statement**: Create and maintain patient-specific allergy, intolerance and adverse reaction lists. **Description**: Allergens, including immunizations, and substances are identified and coded (whenever possible) and the list is captured and maintained over time. All pertinent dates, including patient-reported events, are stored and the description of the patient allergy and adverse reaction is modifiable over time. The entire allergy history, including reaction, for any allergen is viewable. The list(s) includes all reactions including those that are classifiable as a true allergy, intolerance, side effect or other adverse reaction to drug, dietary or environmental triggers. Notations indicating whether item is patient reported and/or provider verified are maintained.	DC.2.3.1.1 S.2.2.1 S.2.2.3 S.3.7.1 IN.2.5.1 IN.2.5.2 IN.4.1 IN.4.2 IN.4.3 IN.6	1. The system **SHALL** provide the ability to capture true allergy, intolerance, and adverse reaction to drug, dietary or environmental triggers as unique, discrete entries.	127	DC.1.4.1	1	N/C
						2. The system **SHOULD** provide the ability to capture the reason for entry of the allergy, intolerance or adverse reaction.	128	DC.1.4.1	2	N/C
						3. The system **SHALL** provide the ability to capture the reaction type.	129	DC.1.4.1	3	N/C
						4. The system **SHOULD** provide the ability to capture the severity of a reaction.	130	DC.1.4.1	4	N/C
						5. The system **SHALL** provide the ability to capture a report of No Known Allergies (NKA) for the patient.	131	DC.1.4.1	5	N/C
						6. The system ~~**SHOULD**~~ **SHALL** provide the ability to capture a report of No Known Drug Allergies (NKDA) for the patient.	132	DC.1.4.1	6	M
						7. The system **SHOULD** provide the ability to capture the source of allergy, intolerance, and adverse reaction information.	133	DC.1.4.1	7	N/C

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						8. The system **SHALL** provide the ability to deactivate an item on the list.	134	DC.1.4.1	8	N/C
						9. The system **SHALL** provide the ability to capture the reason for deactivation of an item on the list.	135	DC.1.4.1	9	N/C
						10. The system ~~**MAY**~~ **SHALL** provide the ability to present allergies, intolerances and adverse reactions that have been deactivated as well as the reason for deactivation.	136	DC.1.4.1	10	M
						10a. 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.	137			A
						11. The system ~~**MAY**~~ **SHOULD** provide the ability to display user defined sort order of list.	138	DC.1.4.1	11	M
						12. The system **SHOULD** provide the ability to indicate that the list of allergies to medications and other agents has been reviewed.	139	DC.1.4.1	12	M
						13. They system **SHALL** provide the ability to capture and display the date on which allergy information was entered.	140	DC.1.4.1	13	N/C
						14. The system **SHOULD** provide the ability to capture and display the approximate date of the allergy occurrence.	141	DC.1.4.1	14	N/C
DC.1.4.2	**F**	**EN**	Manage Medication List	**Statement**: Create and maintain patient-specific medication lists. **Description**: Medication lists are managed over time, whether over the course of a visit or stay, or the lifetime of a patient. All pertinent dates, including medication start, modification, and end dates are stored. The entire medication	S.2.2.1 IN.2.5.1 IN.2.5.2 IN.4.1 IN.4.2 IN.4.3	1. The system **SHALL** provide the ability to capture patient-specific medication lists.	142	DC.1.4.2	1	N/C
						2. The system **SHALL** display and report patient-specific medication lists.	143	DC.1.4.2	2	N/C

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				history for any medication, including alternative supplements and herbal medications, is viewable. Medication lists are not limited to medication orders recorded by providers, but may include, for example, pharmacy dispense/supply records, patient-reported medications and additional information such as age specific dosage.	IN.5.1 IN.5.2 IN.5.4 IN.6	3. The system **SHALL** provide the ability to capture the details of the medication such as ordering date, dose, route, and SIG (description of the prescription, such as the quantity) when known.	144	DC.1.4.2	3	N/C
						4. The system ~~**SHOULD**~~ **SHALL** provide the ability to capture other dates associated with medications such as start and end dates.	145	DC.1.4.2	4	M
						5. The system **SHALL** provide the ability to capture medications not reported on existing medication lists or medication histories.	146	DC.1.4.2	5	N/C
						6. The system **SHALL** provide the ability to capture non-prescription medications including over the counter and complementary medications such as vitamins, herbs and supplements.	147	DC.1.4.2	6	N/C
						7. The system **SHALL** present the current medication lists associated with a patient.	148	DC.1.4.2	7	N/C
						8. The system ~~**SHOULD**~~ **SHALL** have the ability to present the medication history associated with a patient.	149	DC.1.4.2	8	M
						9. The system **SHALL** present the medication, prescriber, and medication ordering dates when known.	150	DC.1.4.2	9	N/C
						10. The system **SHALL** provide the ability to mark a medication as erroneously captured and ~~exclude~~ should be excluded from the presentation of current medications.	151	DC.1.4.2	10	M
						11. The system **SHALL** provide the ability to print a current medication list for patient use.	152	DC.1.4.2	11	N/C

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						12. The system **MAY** provide the ability to capture information regarding the filling of prescriptions (dispensation of medications by pharmacies or other providers).	153	DC.1.4.2	12	N/C
DC.1.4.3	**F**	**EN**	Manage Problem List	**Statement**: Create and maintain patient-specific problem lists. **Description**: A problem list includes at a minimum the patient's active and historical diagnoses, and any problems/needs identified on the care plan. ~~A problem list.~~ It may also include, but is not limited to: other chronic conditions, ~~diagnoses, or~~ symptoms, functional limitations, visit or stay-specific conditions, ~~diagnoses, or symptoms~~ or family and situational conditions adversely impacting the patient. Problem lists are managed over time, whether over the course of a visit or stay or the life of a patient, allowing documentation of historical information and tracking the changing character of problem(s) and their priority. The source (e.g., the provider, the system ID, or the patient) of the updates should be documented. In addition all pertinent dates are stored ~~All pertinent dates are stored~~, including date noted or diagnosed, dates of any changes in problem specification or prioritization, and date of resolution. This might include time stamps, where useful and appropriate. The entire problem history for any problem in the list is viewable.	DC.2.1.3 S.2.2.1 S.3.3.5 IN.2.4 IN.2.5.1 IN.2.5.2 IN.4.1 IN.4.2 IN.4.3 IN.6	1. The system **SHALL** capture, display and report all active problems associated with a patient.	154	DC.1.4.3	1	N/C
						2. The system **SHALL** capture, display and report a history of all problems associated with a patient.	155	DC.1.4.3	2	N/C
						3. The system **SHALL** provide the ability to capture onset date of problem when known.	156	DC.1.4.3	3	M
						4. The system **SHOULD** provide the ability to capture the chronicity (chronic, acute/self-limiting, etc.) of a problem.	157	DC.1.4.3	4	N/C
						5. The system **SHALL** provide the ability to capture the source, date and time of all updates to the problem list.	158	DC.1.4.3	5	N/C
						6. The system **SHALL** provide the ability to deactivate a problem.	159	DC.1.4.3	6	N/C
						7. The system **MAY** provide the ability to re-activate a previously deactivated problem.	160	DC.1.4.3	7	N/C
						8. The system ~~**SHOULD**~~ **SHALL** provide the ability to display inactive and/or resolved problems.	161	DC.1.4.3	8	M
						9. The system ~~**SHOULD**~~ **SHALL** provide the ability to manually order/sort the problem list.	162	DC.1.4.3	9	M
						10. The system ~~**MAY**~~ **SHOULD** provide the ability to associate problems with other clinical items or events (for example: encounters, orders, medications and notes). ~~with one or more problems~~	163	DC.1.4.3	10	M

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DC.1.4.4	**F**	**EN**	Manage Immunization List	**Statement:** Create and maintain patient-specific immunization lists. **Description**: Immunization lists are managed over time, whether over the course of a visit or stay, or the lifetime of a patient. Details of immunizations administered are captured as discrete data elements including date, type, manufacturer and lot number. The entire immunization history is viewable.		1. The system **SHALL** capture, display and report all immunizations associated with a patient	164	DC.1.4.4	1	N/C
						2. The system **SHALL** record as discrete data elements data associated with any immunization given including date, type, lot number and manufacturer	165	DC.1.4.4	2	N/C
						3. The system **SHOULD** provide the ability to prepare a report of a patient's immunization history ~~upon request for appropriate authorities such as schools or day-care centers~~.	166	DC.1.4.4	3	M
DC.1.5	**F**	**EN**	Manage Assessments	**Statement**: Create and maintain assessments. **Description**: ~~During an encounter with a patient, the provider will conduct an assessment that is germane to the age, gender, developmental or functional state, medical and behavioral condition of the patient, such as growth charts, developmental profiles, and disease specific assessments. Wherever~~	DC.1.5 DC.1.6.2 DC.1.10.1 DC.2.1.1 DC.2.1.2 DC.2.2.1 S.2.2.1	1. The system **SHALL** provide the ability to create "user-defined" and standard assessments for clinician use in assessing patient condition.	167	DC.1.5	1	M
						2. The system ~~**SHOULD**~~ **SHALL** provide the ability to ~~use~~ complete, maintain and transmit standardized assessment instruments (such as the Minimum Data Set) ~~where they exist~~ as mandated by jurisdictional regulations.	168	DC.1.5	2	M

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				~~possible, this assessment should follow industry standard protocols although, for example, an assessment for an infant will have different content than one for an elderly patient. When a specific standard assessment does not exist, a unique assessment can be created, using the format and data elements of similar standard assessments whenever possible~~. The EHR-S must be able to provide users with the clinically appropriate and regulatory mandated assessments required to be completed during a patient stay. To support this, the system must allow providers to create, maintain, and make available for clinician use: • user-defined assessments reflecting assessment content and protocols as per facility policy (such as Nursing Admission assessments, Dietary admission assessments, Physical Therapy evaluations, etc.), and • standard assessments reflecting assessment content and protocols as per industry and professional standards of practice (such as the Geriatric Depression Scale, AIMS, Mini-Mental, Falls Risk Assessment, etc.) In addition, the EHR-S must maintain and make available for clinician use any standardized assessment instruments (such as the MDS) that are required by jurisdictional regulation.	IN.1.6 IN.2.5.1 IN.2.5.2 IN.4.1 IN.4.2 IN.4.3 IN.5.1 IN.5.2 IN.6	3. The system ~~**SHOULD**~~ **SHALL** provide the ability to ~~document using~~ complete and maintain "user-defined" and standard assessments ~~germane to the age, gender, developmental state, and health condition as appropriate to the EHR user's scope of practice~~ of resident condition as required by: a) the Conditions of Participation for Medicare and Medicaid (i.e., assessments related to resident risk of dehydration, unintended weight loss, or pressure ulcers), b) jurisdictional regulations, c) professional standards of practice, and d) facility policy.	169	DC.1.5	3	M
						4. ~~The system SHOULD provide the ability to capture data relevant to standard assessment~~ .	170	DC.1.5	4	D
						5. The system **SHOULD** provide the ability to capture additional data to augment ~~the~~ standard assessments relative to variances in medical conditions.	171	DC.1.5	5	M
						6. The system **SHOULD** provide the ability to link data from an ~~standard~~ assessment to a problem list.	172	DC.1.5	6	M
						7. The system **SHOULD** provide the ability to link data from an ~~standard~~ assessment to an individual care plan.	173	DC.1.5	7	M
						8. The system **MAY** provide the ability to link data from external sources, laboratory results, and radiographic results to ~~the standard~~ an assessment.	174	DC.1.5	8	M

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				The EHR-S must provide the ability for clinicians to complete these assessments (user-defined assessments, standard assessments, and standardized assessment instruments) and maintain them as part of the electronic patient record. The EHR-S should provide the ability to capture additional data to augment an assessment as necessary, and should link data from the assessment to the patient's problem list and care plan.		9. The system ~~**SHOULD**~~ **MAY** provide the ability to compare documented data against standardized curves and display the trends.	175	DC.1.5	9	M
						9a. The system **SHOULD** conform to function DC.2.1.1 (Support for Standard Assessments).	176			A
						9b. The system **SHOULD** conform to function DC.2.1.2 (Support for Patient Context-Driven Assessments).	177			A
						9c. The system **SHALL** provide the ability to retrieve prior versions of completed user-defined and standard assessments.	178			A
						10. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	179	DC.1.5	10	N/C
						11. The system **SHALL** conform to function IN.2.2 (Auditable Records).	180	DC.1.5	11	N/C
DC.1.5.1	**F**	**EN**	Capture and Manage the CMS Resident Assessment Instrument	**Statement**: Capture and manage the Minimum Data Set as per CMS regulations **Description**: The resident assessment process mandated by the Centers for Medicare & Medicaid Services (CMS) includes a standardized assessment instrument (the MDS), triggers and protocols for further assessment (Resident Assessment Protocols), and utilization guidelines that define the		1. The system **SHALL** provide the ability to capture all data elements as defined in the most recent MDS data specification.	181			A
						2. The system **SHALL** perform Medicare payment calculations from MDS data items in accordance with the most recent algorithms provided by CMS and populate the payment calculation value to the appropriate MDS data element.	182			A

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				frequency, timeliness, error correction process, and data submission requirements for the Minimum Data Set. In addition, some state agencies impose further, more stringent requirements on MDS processes. The EHR-S must provide the ability to comply with all federal requirements related to the MDS, as well as the additional state level requirements imposed by the jurisdiction in which the system is implemented. *Note*: References to "version" in this function are referring to prior iterations of the mandated assessment instrument.		3. The system **SHALL** perform State Medicaid payment calculations from MDS data items in accordance with the most recent algorithms provided by the state agency of the jurisdiction in which the system is implemented, and populate the payment calculation value to the appropriate data element as required by jurisdictional law or regulation.	183			A
						4. The system **SHALL** perform data consistency edits as defined in the most recent MDS data specification.	184			A
						5. The system **SHALL** calculate triggered Resident Assessment Protocols (RAPs) in accordance with the most recent MDS data specification.	185			A
						6. The system **SHALL** provide the ability to capture the clinician assessment process for triggered Resident Assessment Protocols (RAPs).	186			A
						7. The system **SHALL** create MDS data submission files in accordance with the most recent MDS data specifications.	187			A
						8. The system **SHALL** implement MDS data correction and assessment locking processes as defined in the most recent version of the CMS MDS Correction Policy.	188			A
						9. The system **SHOULD** calculate and report quality calculations such as Quality Indicators and Quality Measures in compliance with function S.2.1.2 (Performance and Accountability Measures).	189			A

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						10. The system **SHALL** report Medicare payment calculations in compliance with function S.3.1.3 (Automatic Generation of Administrative and Financial Data from Clinical Record).	190			A
						11. The system **SHOULD** provide the ability to link data from the MDS to a problem list.	191			A
						12. The system **SHOULD** provide the ability to link data from the MDS to an individual care plan.	192			A
						13. The system SHOULD provide the ability to exchange MDS assessment data in conformance with HL7 CDA release 2 or higher.	193			A
						14. The system **SHALL** provide the ability to export MDS data in formats as required by jurisdictional authority.	194			A
						15. The system **SHALL** provide the ability to access, view, report and display all previously completed MDS assessments.	195			A
						16. The system **MAY** provide the ability to capture all data elements as defined in previous MDS data specifications for purposes of transitioning paper documentation to electronic format**.**	196			A
						17. The system **MAY** create MDS data submission files in accordance with previous MDS data specifications for purposes of transitioning paper documentation to electronic format**.**	197			A

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						18. The system **MAY** implement MDS data correction and assessment locking processes as defined in prior versions of the CMS MDS Correction Policy for purposes of transitioning paper documentation to electronic format.	198			A
						19. The system **MAY** calculate triggered Resident Assessment Protocols (RAPs) in accordance with previous MDS data specifications for purposes of transitioning paper documentation to electronic format**.**	199			A
						20. The system **MAY** perform data consistency edits as defined in previous MDS data specifications for purposes of transitioning paper documentation to electronic format.	200			A
						21. The system **SHOULD** comply with IN 5.1 (Interchange Standards) Criteria #9 (The system SHOULD provide the ability to exchange federally mandated assessment instrument data in conformance with Consolidated Health Informatics (CHI) format and content standards.)	201			A
DC.1.6	**H**	**EN**	Care Plans, Treatment Plans, Guidelines, and Protocols				202	DC.1.6		N/C
DC.1.6.1	**F**	**EN**	Present Guidelines and Protocols for Planning Care	**Statement**: Present organizational guidelines for patient care as appropriate to support planning of care, including order entry and clinical documentation. **Description**: Guidelines, and protocols presented for planning care may be site specific, community or industry-wide standards. It is not the intent of this	DC.1.1.2 DC.2.2.1.1 DC.2.2.1.2 DC.2.2.2	1. The system **SHALL** provide the ability to present current guidelines and protocols to clinicians who are creating plans for treatment and care.	203	DC.1.6.1	1	N/C
						2. The system **SHOULD** provide the ability to search for a guideline or protocol based on appropriate criteria (such as problem).	204	DC.1.6.1	2	N/C

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				function to suggest that guidelines and protocols are presented for all entries in the care plan. Unlike the medical model used in acute care settings, the social model of care used in LTC does not lend itself as easily to the use of standard guidelines and protocols. LTC care planning incorporates the MDS and RAP process (as well as other assessments/orders) to identify social as well as physical strengths and deficits. There may be no "standard protocol" for how to measure or further assess "strength in faith". However where relevant guidelines and protocols do exist, they are presented to the user.	DC.2.2.3 DC.2.7.1 S.3.7.1 IN.6	3. The system **SHOULD** provide the ability to present previously ~~used~~ versions of guidelines and protocols available to clinicians for historical or legal purposes.	205	DC.1.6.1	3	M
						4. IF decision support prompts are used to support a specific clinical guideline or protocol, THEN the system **SHALL** conform to function DC.1.8.6 (Manage Documentation of Clinician Response to Decision Support Prompts).	206	DC.1.6.1	4	N/C
						5. The system **SHALL** conform to function DC.2.2.1.2 (Support for Context-Sensitive Care Plans, Guidelines, Protocols).	207	DC.1.6.1	5	N/C
						6. The system **SHOULD** conform to function IN.2.2 (Auditable Records).	208	DC.1.6.1	6	N/C
DC.1.6.2	**F**	**EN**	Manage Patient-Specific Care and Treatment Plans	**Statement**: Provide administrative tools for healthcare organizations to build care plans, guidelines and protocols for use during patient care planning and care. **Description**: Care plans, guidelines or protocols may contain goals or targets for the patient, specific guidance to the providers, suggested orders, and nursing interventions, among other items. Tracking of implementation or approval dates, modifications and relevancy to specific domains or context is provided. Transfer of treatment and care plans may be implemented electronically using, for example, templates, or by printing plans to paper.	DC.3.1.1 DC.3.1.2 DC.3.1.3 IN.2.2 IN.2.5.1 IN.2.5.2 IN.6	1. The system **SHALL** provide the ability to capture patient-specific plans of care and treatment.	209	DC.1.6.2	1	N/C
						2. The system **SHALL** conform to DC.1.6.1 (Present Guidelines and Protocols for Planning Care) and provide the ability to use locally or non-locally developed templates, guidelines, and protocols for the creation of patient-specific plans of care and treatment	210	DC.1.6.2	2	N/C
						3. The system **SHALL** provide the ability to use a patient's previously developed care plan~~s~~ as a basis for the creation of new plans of care and treatment.	211	DC.1.6.2	3	M

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						4. The system **SHALL** provide the ability to track updates to a patient's plan of care and treatment including authors, creation date, version history, references, local sources and non-local sources in accordance with scope of practice, organizational policy and jurisdictional law.	212	DC.1.6.2	4	N/C
						5. The system **SHOULD** provide the ability to coordinate order sets with care plans.	213	DC.1.6.2	5	N/C
						6. The system ~~**SHOULD**~~ **MAY** provide the ability to ~~derive~~ suggest possible order sets from care plans.	214	DC.1.6.2	6	M
						7. The system **SHOULD** provide the ability to ~~derive~~ suggest care plans from order sets.	215	DC.1.6.2	7	M
						8. The system **SHALL** provide the ability to transfer plans of care and treatment to other care providers.	216	DC.1.6.2	8	N/C
						9. The system **SHOULD** conform to function DC.3.1.1 (Clinical Task Assignment and Routing) and incorporate care plan items in the tasks assigned and routed.	217	DC.1.6.2	9	N/C
						10. The system **SHOULD** conform to function DC.3.1.2 (Clinical Task Linking) and incorporate care plan items in the tasks linked.	218	DC.1.6.2	10	N/C
						11. The system **SHOULD** conform to function DC.3.1.3 (Clinical Task Tracking) and incorporate care plan items in the tasks tracked.	219	DC.1.6.2	11	N/C
						12. The system **SHALL** conform to function IN.2.2 (Auditable Records).	220	DC.1.6.2	12	N/C
DC.1.7	**H**	**EN**	Orders and Referrals Management			1. The system **SHALL** conform to function IN.2.2 (Auditable Records).	221	DC.1.7		N/C

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DC.1.7.1	**F**	**EN**	Manage Medication Orders	**Statement:** Create prescriptions or other medication orders with detail adequate for correct filling and administration. Provide information regarding compliance of medication orders with formularies. **Description**: Different medication orders, including discontinue, refill, and renew, require different levels and kinds of detail, as do medication orders placed in different situations. The correct details are recorded for each situation. Administration or patient instructions are available for selection by the ordering clinicians, or the ordering clinician is facilitated in creating such instructions. The system may allow for the creation of common content for prescription details, including content required in the NCPDP Codified SIG standard. Appropriate time stamps for all medication related activity are generated. This includes series of orders that are part of a therapeutic regimen (e.g., Renal Dialysis, Oncology). When a clinician places an order for a medication, that order may or may not comply with a formulary specific to the patient's location or insurance coverage, if applicable. Whether the order complies with the formulary should be communicated to the ordering clinician at an appropriate point to allow the ordering	DC.2.3.1.1 DC.2.3.1.2 DC.2.3.1.3 DC.2.4.2 DC.3.2.2 S.2.2.1 S.3.3.2 S.3.7.2 IN.2.4 IN.2.5.2 IN.4.1 IN.4.2 IN.4.3 IN.5.1 IN.5.2 IN.5.4 IN.6	1. The system **SHALL** provide the ability to create prescription or other medication orders, such as over the counter (OTC), with the details adequate for correct filling and administration captured as discrete data.	222	DC.1.7.1	1	M
						1a. The system **SHALL** provide the ability to indicate that an existing order has been renewed by the prescriber including prescriber name, and the date and time of renewal.	223			A
						2. The system **SHALL** capture user and date stamp for all prescription related events.	224	DC.1.7.1	2	N/C
						3. The system **SHALL** conform to function DC.1.4.2 (Manage Medication List) and update the appropriate medication list with the prescribed medications (in case of multiple medication lists).	225	DC.1.7.1	3	N/C
						4. The system **SHALL** provide a ~~list of medications to search, including~~ searchable selection list for ordering medications that includes both generic and brand names.	226	DC.1.7.1	4	M
						5. The system **SHALL** provide the ability to maintain a ~~discrete list of orderable medications~~ selection list for ordering medications with components in discrete fields (such as medication name, strength, form).	227	DC.1.7.1	5	M

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				clinician to decide whether to continue with the order. Formulary-compliant alternatives to the medication being ordered may also be presented. In addition, the system should present the clinician with clinical decision support (such as allergies, drug-drug-interactions, etc.) during the medication ordering process. Finally, the EHR-S must support the unique medication ordering processes required in the LTC nursing home environment, including the need to support: • Communication of orders between the physician, nursing facility and pharmacy provider) • Existing practices for monthly signature of renewal orders by physicians (see criterion 1a) • The facility nurse acting as an agent of the physician.		6. The system **SHALL** conform to function DC.1.7.2.1 (Manage Non-Medication Patient Care Orders) and provide the ability to order supplies associated with medication orders in accordance with scope of practice, organizational policy or jurisdictional law.	228	DC.1.7.1	6	N/C
						7. The system ~~**MAY**~~ **SHOULD** make common content (such as drug, dose, route and SIG) available ~~for prescription details~~ to be selected by the ordering clinician.	229	DC.1.7.1	7	M
						8. The system ~~**MAY**~~ **SHALL** provide the ability for the ordering clinician to ~~create~~ enter prescription details (e.g., free text) as needed.	230	DC.1.7.1	8	M
						9. The system **MAY** make available common patient medication instruction content to be selected by the ordering clinician.	231	DC.1.7.1	9	N/C
						10. The system **MAY** provide the ability to include ~~prescriptions~~ medication orders in order sets.	232	DC.1.7.1	10	M
						11. The system **MAY** provide a list of frequently-ordered medications by diagnosis by provider which could include the full details of the medication, including SIG, quantity, refills, DAW, etc.	233	DC.1.7.1	11	N/C
						12. The system **MAY** provide the ability to select drugs by therapeutic class and/or indication.	234	DC.1.7.1	12	N/C
						13. The system ~~**MAY**~~ **SHOULD** conform to function S.3.3.2 (Eligibility Verification and Determination of Coverage) and display the results of electronic prescription eligibility and health plan/payer formulary checking.	235	DC.1.7.1	13	M

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						14. The system **MAY** provide the ability to ~~re-prescribe~~ create a medication order by using data from a prior medication order ~~allowing a prior prescription to be reordered~~ (e.g., without re-entering previous data ~~(e.g.~~ such as administration schedule, quantity).	236	DC.1.7.1	14	M
						15. IF the system ~~**SHOULD**~~ provides the ability to create a medication order by using data from a prior medication order ~~re-prescribe a medication from a prior prescription, using the same dosage but~~ THEN the system **SHALL** allow for editing of details adequate for correct filling and administration of medication (e.g. dose, frequency, body weight).	237	DC.1.7.1	15	M
						16. The system **SHOULD** conform to function DC.2.3.1.1 (Support for Drug Interaction Checking) and check and report allergies, drug-drug interactions, and other potential adverse reactions, when ~~new~~ ordering medications. ~~are ordered~~.	238	DC.1.7.1	16	M
						17. The system **SHOULD** conform to function DC.2.3.1.2 (Support for Patient Specific Dosing and Warnings) and check and report other potential adverse reactions, when new medications are ordered.	239	DC.1.7.1	17	N/C
						18. The system **SHOULD** provide the ability to ~~create prescriptions in which the weight-specific dose is suggested~~ suggest a weight-specific dose during the order entry process.	240	DC.1.7.1	18	M
						19. The system **SHOULD** conform to function DC.2.3.1.3 (Support for Medication Recommendations).	241	DC.1.7.1	19	N/C

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DC.1.7.2	**H**	**EN**	Non-Medication Orders and Referrals Management				242	DC.1.7.2		N/C
DC.1.7.2.1	**F**	**EN**	Manage Non-Medication Patient Care Orders	**Statement**: Capture and track patient care orders. Enable the origination, documentation, and tracking of non-medication patient care orders. **Description**: Non-medication orders that request actions or items can be captured and tracked including new, renewal and discontinue orders. Examples include orders to transfer a patient between units, orders for DNR, to ambulate or reposition a patient, for medical supplies, durable medical equipment, ~~home~~ IVs, and diet or therapy orders. Each item ordered includes the appropriate detail, such as order identification and instructions. Orders should be communicated to the correct service provider for completion.	DC.2.4.1 DC.2.4.2 S.2.2.1 S.3.3.3 S.3.7.1 IN.1.6 IN.1.7 IN.2.5.1 IN.2.5.2 IN.6	1. The system **SHALL** provide the ability to capture non-medication patient care orders for an action or item	243	DC.1.7.2.1	1	N/C
						2. The system **SHALL** provide the ability to capture adequate order detail for correct order fulfillment	244	DC.1.7.2.1	2	N/C
						3. The system **SHALL** provide the ability to track the status (such as active, discontinued, requisitioned, completed) of the ordered action or item.	245	DC.1.7.2.1	3	M
						4. The system **SHOULD** provide the ability to capture patient or caregiver instructions necessary for correct order fulfillment and associate the instructions with the order.	246	DC.1.7.2.1	4	M
						5. The system **SHOULD** provide the ability to present patient and caregiver instructions necessary for correct order fulfillment.	247	DC.1.7.2.1	5	M
						6. The system **SHOULD** provide the ability to communicate the order to the correct recipient(s) for order fulfillment	248	DC.1.7.2.1	6	N/C
						7. The system **SHALL** conform to DC.2.4.2 (Support for Non-Medication Ordering)	249	DC.1.7.2.1	7	N/C
DC.1.7.2.2	**F**	**EN**	Manage Orders for Diagnostic Tests	**Statement**: Enable the origination, documentation, and tracking of orders for diagnostic tests. **Description**: Orders for diagnostic tests (e.g., diagnostic radiology, blood test) are captured and tracked including new,	DC.2.4.5.2 S.2.2.1 S.3.7.1 IN.1.6	1. The system **SHALL** provide the ability to capture orders for diagnostic tests.	250	DC.1.7.2.2	1	N/C
						2. The system **SHALL** provide the ability to capture adequate order detail for correct diagnostic test fulfillment.	251	DC.1.7.2.2	2	N/C

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				renewal and discontinue orders. Each order includes appropriate detail, such as order identification, instructions and clinical information necessary to perform the test. Orders and supporting detailed documentation shall be communicated to the service provider for completion of the diagnostic test(s). This communication should occur through electronic exchange of data using HITSP endorsed standards of interoperability, although other methods of data exchange, including by methods such as automated fax, may be used in the absence of recognized standards. Some systems may contain instructions, but in some settings, instructions may be provided from external sources (e.g., handouts).	IN.1.7 IN.2.5.1 IN.2.5.2 IN.6	3. The system **SHALL** provide the ability to track the status (such as requisitioned, completed, in process) of diagnostic test(s).	252	DC.1.7.2.2	3	M
						4. The system **SHOULD** provide the ability to capture and present patient and caregiver instructions relevant to the diagnostic test ordered.	253	DC.1.7.2.2	4	M
						5. The system **SHALL** provide the ability to communicate orders to the service provider of the diagnostic test.	254	DC.1.7.2.2	5	M
						6. The system **SHOULD** communicate supporting detailed documentation to the correct service provider of the diagnostic test.	255	DC.1.7.2.2	6	N/C
						7. The system **SHALL** conform to DC.2.4.2 (Support for Non-Medication Ordering).	256	DC.1.7.2.2	7	N/C
DC.1.7.2.3	**F**	**O**	Manage Orders for Blood Products and Other Biologics	**Statement**: Communicate with appropriate sources or registries to manage orders for blood products or other biologics. **Description**: Interact with a blood bank system or other source to support orders for blood products or other biologics including discontinuance orders. Use of such products in the provision of care is captured. Blood bank or other functionality that may come under jurisdictional law or other regulation (e.g., by the FDA in the United States) is not required; functional communication with such a system is required.	DC.2.4.5.1 S.1.1 S.1.2	1. The system **SHALL** provide the ability to interface with systems of blood banks or other sources to manage orders for blood products or other biologics.	257	DC.1.7.2.3	1	N/C
						2. The system **SHALL** provide the ability to capture use of such products in the provision of care.	258	DC.1.7.2.3	2	N/C
						3. The system ~~**SHOULD**~~ **SHALL** conform to function S.1.1 (Registry Notification).	259	DC.1.7.2.3	3	M
DC.1.7.2.4	**F**	**EF 2010**	Manage Referrals	**Statement**: Enable the origination, documentation and tracking of referrals between care providers or health care organizations, including clinical and administrative details of the referral, and	DC.1.9.3 DC.2.4.4.1	1. The system **SHALL** provide the ability to capture and communicate referral(s) to other care provider (s), whether internal or external to the organization.	260	DC.1.7.2.4	1	N/C

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				consents and authorizations for disclosures as required. **Description**: Documentation and tracking of a referral from one care provider to another is supported, whether the referred to or referring providers are internal or external to the healthcare organization. The EHR-S provides the ability to capture completion of the referral appointment. This capture functionality can be accomplished via: • external input such as receiving, accepting, downloading or importing a file(s) • internally creating the information by means such as entering, computing or recording information regarding the referral) Guidelines for whether a particular referral for a particular patient is appropriate in a clinical context and with regard to administrative factors such as insurance may be provided to the care provider at the time the referral is created.	DC.2.4.4.2 S.1.3.1a S.1.3.5 S.3.3.2 S.3.3.3 IN.1.6 IN.1.7 IN.2.5.1 IN.2.5.2	2. The system **SHALL** provide the ability to capture clinical details as necessary for the referral.	261	DC.1.7.2.4	2	N/C
						3. The system **SHALL** provide the ability to capture administrative details (such as insurance information, consents and authorizations for disclosure) as necessary for the referral.	262	DC.1.7.2.4	3	N/C
						4. The system **SHALL** present captured referral information.	263	DC.1.7.2.4	4	N/C
						5. The system ~~**SHOULD**~~ **SHALL** provide the ability to capture completion of a referral appointment.	264	DC.1.7.2.4	5	M
						6. The system **SHOULD** provide diagnosis based clinical guidelines for making a referral.	265	DC.1.7.2.4	6	N/C
						7. The system **MAY** provide order sets for referral preparation.	266	DC.1.7.2.4	7	N/C
						8. The system **SHALL** provide the ability to document transfer of care according to organizational policy, scope of practice, and jurisdictional law.	267	DC.1.7.2.4	8	N/C
DC.1.7.3	**F**	**EN**	Manage Order Sets	**Statement**: Provide order sets based on provider input or system prompt. **Description**: Order sets, which may include medication and non-medication orders, allow a care provider to choose common orders for a particular circumstance or disease state according to standards or other criteria. Recommended order sets may be	DC.2.4.1 IN.2.5.1 IN.2.5.2 IN.6	1. The system **SHALL** provide the ability to present order set(s).	268	DC.1.7.3	1	N/C
						2. The system **SHALL** provide the ability to customize orders at the patient level from presented order set templates.	269	DC.1.7.3	2	M
						3. The system **SHALL** provide the ability to record each component of an order set template that is ordered.	270	DC.1.7.3	3	M

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				presented based on patient data or other contexts.		4. The system **SHALL** conform to function DC.2.4.1 (Support for Order Sets).	271	DC.1.7.3	4	N/C
						5. The system ~~**MAY**~~ **SHOULD** provide the ability for a provider to choose from among the order sets pertinent to a certain disease or other criteria.	272	DC.1.7.3	5	M
DC.1.8	**H**	**EN**	Documentation of Care, Measurements and Results			1. The system **SHALL** conform to function IN.2.2 (Auditable Records)	273	DC.1.8	1	N/C
DC.1.8.1	**F**	**EN**	Manage Medication Administration	**Statement**: Present providers with the list of medications that are to be administered to a patient, necessary administration information, and capture administration details. **Description**: In a setting in which medication orders are to be administered by a provider rather than the patient, the necessary information is presented including: the list of medication orders that are to be administered; administration instructions, times or other conditions of administration; dose and route, etc. The system shall securely relate medications to be administered to the unique identity of the patient (see DC.1.1.1). Additionally, the provider can record what actually was or was not administered, whether or not these facts conform to the order. Appropriate time stamps for all medication related activity are generated. For some settings that administer complete sets of medications from a variety of providers' orders, it may be useful to provide an additional check for possible drug-drug or other interactions.	DC.1.1.1 DC.2.3.1.1 DC.2.3.1.2 DC.2.3.2 S.2.2.1 S.2.2.3 IN.1.1 IN.1.2 IN.1.3 IN.1.7 IN.1.9 IN.2.4 IN.2.5.1 IN.2.5.2 IN.6	1. The system **SHALL** present the list of medications that are to be administered.	274	DC.1.8.1	1	M
						2. The system **SHALL** display the timing (e.g., frequency and hour of administration), route of administration, and dose of all medications on the list.	275	DC.1.8.1	2	M
						3. The system ~~**SHOULD**~~ **SHALL** display ~~instructions~~ order directions (SIG) for administration of all medications on the list.	276	DC.1.8.1	3	M
						4. The system ~~**MAY**~~ **SHALL** ~~notify the clinician~~ indicate when ~~specific doses~~ medication related activities are due.	277	DC.1.8.1	4	M
						5. The system ~~**MAY**~~ **SHOULD** conform to function DC.2.3.1.1 (Support for Drug Interaction Checking) and check and report allergies, drug-drug interactions, and other potential adverse reactions (e.g., drug to condition), when new medications are about to be given.	278	DC.1.8.1	5	M
						6. The system ~~**MAY**~~ **SHOULD** conform to function DC.2.3.1.2 (Support for Patient Specific Dosing and Warnings) and check and report other potential adverse reactions, when new medications are about to be given.	279	DC.1.8.1	6	M

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				The EHR system may support the five "rights", as well as other criteria from the CMS State Operations Manual (SOM).		7. The system **SHALL** provide the ability to capture medication administration details -- including timestamps, observations, complications, and reason if medication was not given -- in accordance with organizational policy, scope of practice, and jurisdictional law.	280	DC.1.8.1	7	N/C
						8. The system **SHALL** provide the ability to securely ~~relate interventions~~ associate medication-related activities ~~to be administered~~ to the unique identity of the patient (e.g., verification of administration to correct patient).	281	DC.1.8.1	8	M
DC.1.8.2	**F**	**EN**	Manage Immunization Administration	**Statement**: Capture and maintain discrete data concerning immunizations given to a patient including date administered, type, manufacturer, lot number, and any allergic or adverse reactions. Facilitate the interaction with an immunization registry to allow maintenance of a patient's immunization history. **Description**: During an encounter, recommendations based on accepted immunization schedules are presented to the provider. Allergen and adverse reaction histories are checked prior to giving the immunization. If an immunization is administered, discrete data elements associated with the immunization including date, type, manufacturer and lot number are recorded. Any new adverse or allergic reactions are noted. If required, a report is made to the public health immunization registry.	DC.1.3.2 S.1.1 S.2.2.2 S.3.7.1 IN.1.6 IN.1.7 IN.2.4 IN.2.5.1 IN.2.5.2 IN.3.1 IN.3.2 IN.4.1 IN.4.2 IN.4.3 IN.5.1 IN.5.2	1. The system **SHALL** provide the ability to recommend ~~required~~ immunizations, and when they are due, during an encounter based on widely accepted immunization schedules (such as from the CDC or applicable State departments of health)	282	DC.1.8.2	1	M
						2. The system ~~**SHOULD**~~ **MAY** provide the ability to recommend required immunizations based on patient risk factors.	283	DC.1.8.2	2	M
						3. The system **SHALL** ~~perform checking for~~ check for and report potential adverse or allergic reactions (based on allergen history and adverse reaction history) for all immunizations ~~when they are about to be given~~ immediately prior to administration.	284	DC.1.8.2	3	M
						4. The system **SHALL** provide the ability to capture immunization administration details, including date, type, lot number and manufacturer.	285	DC.1.8.2	4	N/C

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					IN.6	5. The system **SHOULD** provide the ability to capture other clinical data pertinent to the immunization administration (e.g., vital signs).	286	DC.1.8.2	5	N/C
						6. The system **SHALL** record as discrete data elements the data associated with ~~any~~ each immunization administration.	287	DC.1.8.2	6	M
						7. The system **SHOULD** provide the ability to associate standard codes with discrete data elements associated with an immunization.	288	DC.1.8.2	7	N/C
						8. The system **SHALL** provide the ability to update the immunization schedule.	289	DC.1.8.2	8	N/C
						9. The system **SHOULD** provide the ability to prepare a report of a patient's immunization history upon request for appropriate authorities. ~~such as schools or day care centers~~	290	DC.1.8.2	9	M
						10. The system **SHALL** conform to function DC.1.4.1 (Manage Allergy, Intolerance and Adverse Reaction Lists).	291	DC.1.8.2	10	N/C
						11. The system ~~**SHOULD**~~ **MAY** transmit required immunization information to a public health immunization registry.	292	DC.1.8.2	11	M
						12. The system ~~**SHOULD**~~ **MAY** receive immunization histories from a public health immunization registry.	293	DC.1.8.2	12	M
DC.1.8.3	**F**	**EN**	Manage Results	**Statement**: Present, annotate, and route current and historical test results to appropriate providers or patients for review. Provide the ability to filter and compare results. **Description**: Results of tests are presented in an easily accessible	DC.2.4.3 S.2.2.1 S.3.7.1 IN.1.6 IN.1.7	1. The system **SHALL** provide the ability to present numerical and non-numerical current and historical test results ~~to the appropriate provider~~.	294	DC.1.8.3	1	M
						2. The system **SHALL** provide the ability to filter results for a unique patient.	295	DC.1.8.3	2	N/C

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				manner to the appropriate providers. Flow sheets, graphs, or other tools allow care providers to view or uncover trends in test data over time. In addition to making results viewable, it is often necessary to send results to appropriate providers using electronic messaging systems, pagers, or other mechanisms. Documentation of notification is accommodated. Results may also be routed to patients electronically or by letter.	IN.2.4 IN.2.5.1 IN.2.5.2 IN.6	3. The system **SHALL** provide the ability to filter results by factors that supports results management, such as type of test and date range.	296	DC.1.8.3	3	N/C
						4. The system ~~**SHOULD**~~ **SHALL** provide the ability to indicate normal and abnormal results depending on the data source.	297	DC.1.8.3	4	M
						5. The system **SHOULD** provide the ability to filter lab results by range, (e.g., critical, abnormal or normal).	298	DC.1.8.3	5	N/C
						6. The system **SHOULD** display numerical results in flow sheets, graphical form, or other views that ~~and~~ allow comparison of results.	299	DC.1.8.3	6	M
						7. The system **SHALL** provide the ability to group tests ~~done on the same day~~ by date done.	300	DC.1.8.3	7	M
						8. The system **SHOULD** notify relevant providers (ordering, copy to) that new results have been received.	301	DC.1.8.3	8	N/C
						9. The system **SHOULD** provide the ability for the user, to whom a result is presented, to acknowledge the result.	302	DC.1.8.3	9	N/C
						10. The system **SHOULD** provide the ability to route results to other appropriate care providers.~~, such as nursing home, consulting physicians, etc.~~	303	DC.1.8.3	10	M
						11. The system **MAY** provide the ability to route results to patients by methods such as phone, fax, electronically or letter.	304	DC.1.8.3	11	M

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						12. The system ~~**SHOULD**~~ **MAY** provide the ability for providers to ~~pass on the responsibility to perform~~ request follow up actions ~~to~~ from other providers (e.g., attending physician, specialty care physicians, nurse practitioner, psychiatrist, pharmacist, etc.).	305	DC.1.8.3	12	M
						13. The system **MAY** provide the ability for an authorized user to group results into clinically logical sections.	306	DC.1.8.3	13	N/C
						14. The system ~~**SHOULD**~~ **MAY** trigger decision support algorithms from the results.	307	DC.1.8.3	14	M
						15. IF the system contains the electronic order, THEN the results **SHALL** be linked to a specific order.	308	DC.1.8.3	15	N/C
						16. The system ~~**MAY**~~ **SHOULD** provide the ability for providers to annotate a result.	309	DC.1.8.3	16	M
						17. The system ~~**MAY**~~ **SHOULD** display a link to other data (e.g., ~~an~~ images, etc.) associated with or supporting the results report.	310	DC.1.8.3	17	M
DC.1.8.4	**F**	**EN**	Manage Patient Clinical Measurements	**Statement**: Capture and manage patient clinical measures, such as vital signs, as discrete patient data. **Description**: Patient measures such as vital signs are captured and managed as discrete data to facilitate reporting and provision of care. Other clinical measures (such as expiratory flow rate, size of lesion, etc.) are captured and managed, and may be discrete data.	IN.2.5.1 IN.2.5.2	1. ~~IF required by the scope practice, THEN~~ The system **SHALL** provide the ability to capture patient vital signs such as blood pressure, temperature, heart rate, respiratory rate, and severity of pain as discrete elements of structured or unstructured data.	311	DC.1.8.4	1	M
						2. ~~IF required by the scope practice, THEN~~ The system **SHALL** provide the ability to capture ~~psychiatric symptoms~~ mood and behavior and daily functioning as either structured or unstructured data.	312	DC.1.8.4	2	M

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						3. The system **SHOULD** provide the ability to capture other clinical measures ~~such as~~ (e.g., peak expiratory flow rate, size of lesions, oxygen saturation, height, weight, and body mass index) as discrete elements of either structured or unstructured data.	313	DC.1.8.4	3	M
						4. The system ~~**SHOULD**~~ **MAY** compute and display percentile values when data with normative distributions are entered.	314	DC.1.8.4	4	M
						5. The system **MAY** provide normal ranges for data based on age and other parameters such as height, weight, ethnic background, gestational age.	315	DC.1.8.4	5	N/C
DC.1.8.5	**F**	**EN**	Manage Clinical Documents and Notes	**Statement**: Create, addend, correct, authenticate and close, as needed, transcribed or directly-entered clinical documentation and notes. **Description**: Clinical documents and notes may be unstructured and created in a narrative form, which may be based on a template, graphical, audio, etc. The documents may also be structured documents that result in the capture of coded data. Each of these forms of clinical documentation is important and appropriate for different users and situations.	IN.2.2 IN.2.5.1 IN.2.5.2	1. The system **SHALL** provide the ability to capture clinical documentation (henceforth "documentation") including original, update by amendment in order to correct, and addenda.	316	DC.1.8.5	1	N/C
						2. The system **SHALL** provide the ability to capture free text documentation.	317	DC.1.8.5	2	N/C
						3. The system **MAY** present documentation templates (structured or free text) to facilitate creating documentation.	318	DC.1.8.5	3	N/C
						4. The system **SHALL** provide the ability to view other documentation within the patient's logical record while creating documentation.	319	DC.1.8.5	4	N/C
						5. The system **SHOULD** provide the ability to associate documentation for a specific patient with a given event, such as a physician office visit, phone communication, ~~e-mail~~ pharmacist consult, resident injury, lab result, etc.	320	DC.1.8.5	5	M

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						6. The system **SHOULD** provide the ability to associate documentation with problems and/or diagnoses.	321	DC.1.8.5	6	N/C
						7. The system **SHALL** provide the ability to update documentation prior to marking it as complete (finalizing) ~~it~~.	322	DC.1.8.5	7	M
						8. The system **SHALL** provide the ability to mark ~~finalize~~ a document or note as complete (finalize).	323	DC.1.8.5	8	M
						9. The system **SHALL** provide the ability to attribute, record and display the identity of all users contributing to or finalizing a document or note, including the date and time of entry (see appropriate criteria in IN.2.2 (Auditable Records).	324	DC.1.8.5	9	N/C
						10. The system **SHALL** present captured documentation.	325	DC.1.8.5	10	N/C
						11. The system ~~**MAY**~~ **SHALL** provide the ability to filter, search or sort notes.	326	DC.1.8.5	11	M
						12. The system ~~**SHOULD**~~ **MAY** provide documentation templates for data exchange.	327	DC.1.8.5	12	M
DC.1.8.6	**F**	**EN**	Manage Documentation of Clinician Response to Decision Support Prompts	**Statement**: Capture the decision support prompts and manage decisions to accept or override decision support prompts. **Description**: Clinician actions in response to decision support prompts are captured and can be managed at the patient level or aggregated for organizational trending.	S.3.7.1 IN.2.5.1 IN.2.5.2 IN.6	1. IF decision support prompts are used, THEN the system **SHALL** provide the ability to capture clinical decision support prompts and user decisions to accept or override those prompts.	328	DC.1.8.6	1	M
						2. The system **SHALL** provide the ability to record the reason for variation from the decision support prompt.	329	DC.1.8.6	2	N/C
						3. The system **SHOULD** provide the ability to display recorded variances upon request by authorized users of the EHR.	330	DC.1.8.6	3	N/C

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DC.1.9	**F**	**EF 2012**	Generate and Record Patient-Specific Instructions	**Statement**: Generate and record patient-specific instructions related to pre- and post-procedural and post-discharge requirements. **Description**: When a patient is scheduled for a test, procedure, or discharge, specific instructions about diet, clothing, transportation assistance, convalescence, follow-up with physician, etc., may be generated and recorded, including the timing relative to the scheduled event.	DC.2.2.4 DC.2.7.2 DC.3.2.3 DC.3.2.4 S.3.7.2 S.3.7.3 IN.1.8 IN.2.2 IN.6	1. The system **SHALL** provide the ability to generate standardized instruction sets pertinent to the patient condition, ~~for standardized~~ procedures, or scheduled events.	331	DC.1.9	1	M
						2. The system **SHALL** provide the ability to generate instructions pertinent to the patient ~~based on clinical~~ and subject to the clinician's judgment.	332	DC.1.9	2	M
						3. The system **SHALL** provide the ability to include details on further care such as follow up, return visits and appropriate timing of further care.	333	DC.1.9	3	N/C
						4. The system **SHALL** provide the ability to record that instructions were given to the patient.	334	DC.1.9	4	N/C
						5. The system **SHALL** provide the ability to record the actual instructions given to the patient or reference the document(s) containing those instructions.	335	DC.1.9	5	N/C
						6. The system **SHALL** conform to function IN.2.2 (Auditable Records).	336	DC.1.9	6	N/C
DC.2	**H**	**EN**	**Clinical Decision Support**			1. The system **SHALL** conform to function IN.1.1 (Entity Authentication).	337	DC.2	1	N/C
						2. The system **SHALL** conform to function IN.1.2 (Entity Authorization).	338	DC.2	2	N/C
						3. The system **SHALL** conform to function IN.1.3 (Entity Access Control).	339	DC.2	3	N/C
						4. IF the system is used to enter, modify or exchange data, THEN the system **SHALL** conform to function IN.1.5 (Non-Repudiation), to guarantee that the sources and receivers of data cannot deny that they entered/sent/received the data.	340	DC.2	4	N/C

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								ID #	Criteria #	Criteria Status
						5. IF the system exchanges data outside of a secure network, THEN the system **SHALL** conform to function IN.1.6 (Secure Data Exchange), to ensure that the data are protected.	341	DC.2	5	N/C
						6. IF the system exchanges outside of a secure network, THEN the system **SHALL** conform Function IN.1.~~7~~ 10 (Secure Data Routing - LTC), to ensure that the exchange occurs only among authorized senders and receivers.	342	DC.2	6	M
						7. IF the system is used to enter or modify data in the health record, THEN the system **SHALL** conform to function IN.1.8 (Information Attestation), to show authorship and responsibility for the data.	343	DC.2	7	N/C
						8. The system **SHALL** conform to function IN.2.1 (Data Retention, Availability and Destruction).	344	DC.2	8	N/C
						9. The system **SHOULD** conform to function IN.2.3 (Synchronization).	345	DC.2	9	N/C
						10. IF the system is used to extract data for analysis and reporting, THEN the system **SHALL** conform to function IN.2.4 (Extraction of Health Record Information), to support data extraction across the complete health record of an individual.	346	DC.2	10	N/C
						11. IF the system stores unstructured data, THEN the system **SHALL** conform to function IN.2.5.1 (Manage Unstructured Health Record Information), to ensure data integrity through all changes.	347	DC.2	11	N/C

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						12. IF the system stores structured data, THEN the system **SHALL** conform to function IN.2.5.2 (Manage Structured Health Record Information), to ensure data integrity through all changes.	348	DC.2	12	N/C
						13. IF the system processes data for which generally accepted standard terminologies have been established, THEN the system **SHALL** conform to function IN.4.1 (Standard Terminologies and Terminology Models), to support semantic interoperability.	349	DC.2	13	N/C
						14. IF the system processes data for which generally accepted standard terminologies have been established, THEN the system **SHALL** conform to function IN.4.2 (Maintenance and Versioning of Standard Terminologies), to preserve the semantics of coded data over time.	350	DC.2	14	N/C
						15. The system **SHOULD** conform to function IN.4.3 (Terminology Mapping).	351	DC.2	15	N/C
						16. IF the system exchanges data for which generally accepted interchange standards have been established, THEN the system **SHALL** conform to function IN.5.1 (Interchange Standards), to support interoperability.	352	DC.2	16	N/C

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						17. IF the system exchanges data for which generally accepted interchange standards have been established, THEN the system **SHALL** conform to function IN.5.2 (Interchange Standards Versioning and Maintenance), to accommodate the inevitable evolution of interchange standards.	353	DC.2	17	N/C
						18. The system **SHOULD** conform to function IN.5.3 (Standards-based Application Integration).	354	DC.2	18	N/C
						19. IF the system exchanges data with other systems outside itself, THEN the system **SHALL** conform to function IN.5.4 (Interchange Agreements), to define how the sender and receiver will exchange data.	355	DC.2	19	N/C
						20. The system **SHOULD** conform to function IN.6 (Business Rules Management).	356	DC.2	20	N/C
						21. The system **SHOULD** conform to function IN.7 (Workflow Management).	357	DC.2	21	N/C
DC.2.1	**H**	**EN**	Manage Health Information to Provide Decision Support			1. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	358	DC.2.1	1	N/C
						2. The system **SHALL** conform to function IN.1.9 (Patient Privacy and Confidentiality).	359	DC.2.1	2	N/C
						3. The system **SHALL** conform to function IN.2.2 (Auditable Records).	360	DC.2.1	3	N/C
						4. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	361	DC.2.1	4	N/C
DC.2.1.1	**F**	**EN**	Support for Standard Assessments	**Statement**: Offer prompts to support the adherence to care plans, guidelines, and protocols at the point of information capture.	DC.1.4 DC.1.5 S.3.7.1	1. The system **SHALL** provide the ability to access ~~the~~ standard assessments in the patient record.	362	DC.2.1.1	1	N/C

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				Description: When a clinician fills out an assessment, data entered triggers the system to prompt the assessor to consider issues that would help assure a complete/accurate assessment. A simple demographic value or presenting problem (or combination) could provide a template for data gathering that represents best practice in this situation, (e.g., ~~Type II diabetic review, fall and 70+, rectal bleeding, etc.~~ risk assessments, psychotherapeutic drug use, incontinence, etc. Examples of accessing 'best practices' include internal application links to clinical resources or evidence-based resources, facility defined help text, etc.)	IN.2.3 IN.2.4 IN.6	2. The system **SHALL** provide the ability to access ~~to~~ health standards and practices related to standard assessment and appropriate to the EHR user's scope of practice.	363	DC.2.1.1	2	M
						3. The system **SHOULD** provide the ability to compare elements of assessments captured by the clinician and those available as best practices and/or evidence based resources.	364	DC.2.1.1	3	N/C
						4. The system **MAY** provide the ability to derive supplemental assessment data from evidence based standard assessments, practice standards, or other generally accepted, verifiable, and regularly updated standard clinical sources.	365	DC.2.1.1	4	N/C
						5. The system **SHOULD** provide prompts based on practice standards to recommend additional assessment functions.	366	DC.2.1.1	5	N/C
						6. The system **SHOULD** conform to function DC.1.4.3 (Manage Problem List) and provide the ability to update the problem list by activating new problems and de-activating old problems as identified by conduct of standard assessments.	367	DC.2.1.1	6	N/C
						7. The system **SHOULD** provide the ability to ~~create standard assessments that correspond to~~ prompt additional areas to be assessed as triggered by the problem list.	368	DC.2.1.1	7	M
						8. The system **SHOULD** conform to function DC 2.1.2 (Support for Patient Context-driven Assessments).	369	DC.2.1.1	8	N/C

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DC.2.1.2	**F**	**EN**	Support for Patient Context-Driven Assessments	**Statement**: Offer prompts based on patient-specific data at the point of information capture for assessment purposes. **Description**: When a clinician fills out an assessment, data entered is matched against data already in the system to identify potential linkages. For example, the system could scan the medication list and the knowledge base to see if any of the symptoms are side effects of medication already prescribed. Important diagnoses could be brought to the doctor's attention, for instance ~~ectopic pregnancy in a woman of child bearing age~~ appendicitis in a geriatric patient who has abdominal pain.	DC.1.4 DC.1.5 S.3.7.1 IN.2.3 IN.2.4 IN.6	1. The system **SHALL** provide the ability to access health assessment data in the patient record	370	DC.2.1.2	1	N/C
						2. The system **SHOULD** provide the ability to compare assessment data entered during the encounter and the accessed health evidence based standards and best practices	371	DC.2.1.2	2	N/C
						3. The system **SHOULD** provide the ability to compare health data and patient context-driven assessments to practice standards, ~~in order to~~ providing prompts such as additional assessments, testing, possible diagnoses, or adjunctive treatment.	372	DC.2.1.2	3	M
						4. The system **SHOULD** provide the ability to correlate assessment data and the data in the patient specific problem list.	373	DC.2.1.2	4	N/C
						5. The system **SHALL** conform to function DC 2.1.1 (Support for Standard Assessments)	374	DC.2.1.2	5	N/C
						6. The system **SHALL** conform to function DC.1.5 (Manage Assessments)	375	DC.2.1.2	6	N/C
						7. The system **SHOULD** conform to function DC.1.4.3 (Manage Problem List)	376	DC.2.1.2	7	N/C
DC.2.1.3	**F**	**EN**	Support for Identification of Potential Problems and Trends	**Statement**: Identify trends that may lead to significant problems, and provide prompts for consideration. **Description**: When personal health information is collected directly during a patient visit, input by the patient, or acquired from an external source (lab results), it is important to be able to identify potential problems and trends that may be patient-specific, given the	DC.1.4 DC.1.5 S.3.7.1 S.3.7.2 S.3.7.4 IN.6	1. The system **SHALL** conform to function DC.1.5 (Manage Assessments) and provide the ability to access standard assessment data in the patient record.	377	DC.2.1.3	1	N/C
						2. The system **SHOULD** provide the ability to access health standards and practices appropriate to the EHR user's scope of practice at the time of the encounter.	378	DC.2.1.3	2	N/C

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				individual's personal health profile, or changes warranting further assessment. For example: significant trends (lab results, weight); a decrease in creatinine clearance for a patient on metformin, an abnormal increase in INR for a patient on warfarin, an increase in suicidal ideation; presence of methamphetamines; or absence of therapeutic levels of antidepressants.		3. The system **SHOULD** provide the ability to compare patient context-driven assessments and additional health information to best practices in order to identify patient specific growth or development patterns, health trends and potential health problems.	379	DC.2.1.3	3	N/C
						4. The system **SHOULD** provide the ability to configure rules defining abnormal trends.	380	DC.2.1.3	4	N/C
						5. The system **SHOULD** prompt the provider with abnormal trends.	381	DC.2.1.3	5	N/C
						6. The system **SHOULD** prompt the provider for additional assessments, testing or adjunctive treatment.	382	DC.2.1.3	6	N/C
						7. The system **SHOULD** conform to function DC.1.8.6 (Manage Documentation of Clinician Response to Decision Support Prompts).	383	DC.2.1.3	7	N/C
						8. The system **MAY** provide the ability to integrate health information contained in the record with appropriate teaching materials.	384	DC.2.1.3	8	N/C
						9. The system **SHOULD** conform to function DC 2.2.1.2 (Support for Context-sensitive Care Plans, Guidelines, Protocols).	385	DC.2.1.3	9	N/C
DC.2.1.4	**F**	**EN**	Support for Patient and Family Preferences	**Statement**: Support the integration of patient and family preferences into clinical decision support. **Description**: Decision support functions should permit consideration of patient/family preferences and concerns, such as with language, religion, culture,	DC.1.1.4 DC.1.6.1 DC.1.6.2 DC.1.6.3 DC.1.11.1	1. The system **SHALL** conform to DC.1.3.1 (Manage Patient and Family Preferences).	386	DC.2.1.4	1	N/C
						2. The system **SHALL** provide for the ability to capture and manage patient and family preferences as they pertain to current treatment plans.	387	DC.2.1.4	2	N/C

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				medication choice, invasive testing, and advance directives. Such preferences should be captured in a manner that allows for their integration with the health record and easy retrieval from the health record. Preferences may be specified across all treatment plans or specifically to a treatment plan.	DC.1.11.2 DC.2.2.1.1 DC.2.2.1.2 DC.2.2.2 S.3.7.1 S.3.7.2 S.3.7.4 IN.6	3. The system **SHALL** provide the ability to update care guidelines and options relating to documented patient and family preferences, including standards of practice (e.g., treatment options for individuals who refuse ~~blood transfusions~~ IV hydration as part of their advanced directives).	388	DC.2.1.4	3	M
						4. The system ~~**SHOULD**~~ **MAY** provide the ability to compare care guidelines and options relating to documented patient and family preferences, including standards of practice.	389	DC.2.1.4	4	M
						5. The system ~~**SHOULD**~~ **MAY** prompt the provider for testing and treatment options based on patient and family preferences and provide the ability to compare to standard practice.	390	DC.2.1.4	5	M
						6. The system **MAY** provide the ability to integrate preferences with appropriate teaching materials.	391	DC.2.1.4	6	N/C
						7. The system ~~**SHOULD**~~ **SHALL** provide the ability to integrate necessary documentation of preferences, such as ~~living wills~~, advance directives, health care proxies, specific consents or releases.	392	DC.2.1.4	7	M
						8. The system **SHALL** conform to function DC.1.3.2 (Manage Patient Advance Directives).	393	DC.2.1.4	8	N/C
DC.2.2	**H**	**EN**	Care and Treatment Plans, Guidelines and Protocols		DC.1.2	1. The system **SHALL** conform to function IN.1.9 (Patient Privacy and Confidentiality).	394	DC.2.2	1	N/C
						2. The system **SHALL** conform to function IN.2.2 (Auditable Records).	395	DC.2.2	2	N/C

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DC.2.2.1	**H**	**EN**	Support for Condition Based Care and Treatment Plans, Guidelines, Protocols			1. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	396	DC.2.2.1	1	N/C
						2. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	397	DC.2.2.1	2	N/C
DC.2.2.1.1	**F**	**EN**	Support for Standard Care Plans, Guidelines, Protocols	**Statement**: Support the use of appropriate standard care plans, guidelines and/or protocols for the management of specific conditions. **Description**: Before they can be accessed upon request (e.g., in DC 1.6.1), standard care plans, protocols, and guidelines must be created. These documents may reside within the system or be provided through links to external sources, and can be modified and used on a site specific basis. To facilitate retrospective decision support, variances from standard care plans, guidelines, and protocols can be identified and reported. It is not the intent of this function to suggest that guidelines and protocols are presented for all entries in the care plan. Unlike the medical model used in acute care settings, the social model of care used in LTC does not lend itself as easily to the use of standard guidelines and protocols. LTC care planning incorporates the MDS and RAP process (as well as other assessments/orders) to identify social as well as physical strengths and deficits. There may be no "standard protocol" for how to measure or further assess "strength in faith". However where relevant guidelines and protocols do exist, they are presented to the user.	DC.1.6.1	1. The system **SHALL** conform to function DC.1.6.1 (Present Guidelines and Protocols for Planning Care) and provide the ability to access standard care plans, protocols and guidelines when requested within the context of a clinical encounter.	398	DC.2.2.1.1	1	N/C
						2. The system ~~**MAY**~~ **SHOULD** provide the ability to create and use site-specific care plans, protocols, and guidelines.	399	DC.2.2.1.1	2	M
						3. The system ~~**MAY**~~ **SHOULD** provide the ability to make site-specific modifications to standard care plans, protocols, and guidelines obtained from outside sources.	400	DC.2.2.1.1	3	M
						4. The system **SHOULD** identify, track and provide alerts, notifications and reports about significant variances from standard care plans, guidelines and protocols.	401	DC.2.2.1.1	4	M
						5. The system **SHALL** conform to DC.2.2.1.2 (Support for Context-Sensitive Care Plans, Guidelines, Protocols).	402	DC.2.2.1.1	5	N/C
						6. The system **SHALL** conform to DC.2.1.1 (Support for Standard Assessments).	403	DC.2.2.1.1	6	N/C

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DC.2.2.1.2	**F**	**EN**	Support for Context-Sensitive Care Plans, Guidelines, Protocols	**Statement**: Identify and present the appropriate care plans, guidelines and/or protocols for the management of patient specific conditions that are identified in a patient clinical encounter. **Description**: At the time of the clinical encounter (problem identification), recommendations for tests, treatments, medications, immunizations, referrals and evaluations are presented based on evaluation of patient specific data such as age, gender, developmental stage, their health profile, and any site-specific considerations. These may be modified on the basis of new clinical data at subsequent encounters.	DC.1.3.1 DC.1.4 DC.1.5 DC.1.6 DC.1.6.1 DC.1.6.3 S.2.2.1 IN.2.4 IN.6	1. The system **SHALL** provide the ability to access care and treatment plans that are sensitive to the context of patient data and assessments.	404	DC.2.2.1.2	1	N/C
						2. The system **MAY** provide the ability to capture care processes across the continuum of care.	405	DC.2.2.1.2	2	N/C
						3. The system **MAY** present care processes from across the continuum of care.	406	DC.2.2.1.2	3	N/C
						4. The system **MAY** provide the ability to document the choice of action in response to care plan suggestions.	407	DC.2.2.1.2	4	N/C
						5. The system **SHOULD** identify, track and provide alerts, notifications and reports about significant variances from standard care plans, guidelines and protocols.	408	DC.2.2.1.2	5	M
						6. The system **SHALL** conform to function DC.2.2.1.1 (Support for Standard Care Plans, Guidelines, Protocols).	409	DC.2.2.1.2	6	N/C
						7. The system **SHALL** conform to function DC.2.1.1 (Support for Standard Assessments).	410	DC.2.2.1.2	7	N/C
						8. The system **SHALL** conform to function DC.2.1.2 (Support for Patient Context-Driven Assessments).	411	DC.2.2.1.2	8	N/C
DC.2.2.2	**F**	**EF 2012**	Support Consistent Healthcare Management of Patient Groups or Populations	**Statement**: Provide the ability to identify and consistently manage healthcare, over time and across populations or groups of patients, that share diagnoses, problems, functional limitations, treatment, medications, and demographic characteristics that may impact care, (e.g., population management, disease management,	DC.2.2.1.2 S.2.2.2 IN.2.2 IN.6	1. The system **SHALL** conform to DC.2.2.1.2 (Support for Context-Sensitive Care Plans, Guidelines, Protocols).	412	DC.2.2.2	1	N/C
						2. The system **SHALL** provide the ability to identify patients eligible for healthcare management protocols based on criteria identified within the protocol.	413	DC.2.2.2	2	N/C

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				wellness management or care management). **Description**: Populations or groups of patients that share diagnoses (such as diabetes or hypertension), problems, functional limitations, treatment, medication, and demographic characteristics such as race, ethnicity, religion, socio-economic status that may impact care are identified for the clinician. The clinician is advised and assisted with management of these patients to optimize the clinician's ability to provide appropriate care. For example, a clinician is alerted to racial, cultural, religious, socio-economic, living situation and functional accommodations of the patient that are required to provide appropriate care. A further example -- the clinician may be notified of eligibility for a particular test, therapy, or follow-up; availability of supportive resources in the community; or results from audits of compliance of these populations with disease management protocols.		3. The system ~~**SHOULD**~~ **SHALL** provide the ability to include or exclude a patient from an existing health care management protocol group.	414	DC.2.2.2	3	M
						4. The system **SHOULD** provide the ability to audit compliance of selected populations and groups that are the subjects of healthcare management protocols.	415	DC.2.2.2	4	N/C
						5. The system **SHALL** conform to function S.2.2.2 (Standard Report Generation).	416	DC.2.2.2	5	N/C
						6. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	417	DC.2.2.2	6	N/C
DC.2.2.3	**F**	**O**	Support for Research Protocols Relative to Individual Patient Care	**Statement**: Provide support for the management of patients enrolled in research protocols. **Description**: The clinician is presented with appropriate protocols for patients participating in research studies, and is supported in the management and tracking of study participants.	S.1.1 S.1.5 S.2.2.2 S.3.3.1 IN.1.1 IN.1.2 IN.1.3 IN.1.9 IN.2.2	1. The system **SHALL** provide the ability to present protocols for patients enrolled in research studies.	418	DC.2.2.3	1	N/C
						2. The system **SHALL** provide the ability to maintain research study protocols.	419	DC.2.2.3	2	N/C
						3. The system **SHOULD** conform to function S.3.3.1 (Enrollment of Patients), to enable participation in research studies.	420	DC.2.2.3	3	N/C
						4. The system **SHOULD** provide the ability to identify and track patients participating in research studies.	421	DC.2.2.3	4	N/C

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					IN.2.4 IN.4.1 IN.4.2 IN.4.3 IN.5.1 IN.5.2 IN.5.4 IN.6 IN.7	5. The system **MAY** provide the ability to capture appropriate details of patient condition and response to treatment as required for patients enrolled in research studies.	422	DC.2.2.3	5	N/C
						6. The system **SHALL** conform to function S.2.2.2 (Standard Report Generation).	423	DC.2.2.3	6	N/C
						7. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	424	DC.2.2.3	7	N/C
						8. IF research protocols require standardized transmission of data to/from a registry or directory, THEN the system **SHALL** conform to function IN.3 (Registry and Directory Services).	425	DC.2.2.3	8	N/C
DC.2.2.4	**F**	**O**	Support Self-Care	**Statement**: Provide the patient with decision support for self-management of a condition between patient-provider encounters. **Description**: Patients with specific conditions need to follow self-management plans that may include schedules for home monitoring, lab tests, and clinical check ups; recommendations about nutrition, physical activity, tobacco use, etc.; and guidance or reminders about medications. Information to support self-care may be appropriately provided to: 1. the patient 2. a surrogate (parent, spouse, guardian), or 3. others involved directly in the patients self care.	DC.1.1.4 DC.1.11.1 S.3.7.1 S.3.7.2 S.3.7.3 IN.1.4 IN.1.9 IN.6	1. The system **SHALL** provide the ability to present patient guidance and reminders appropriate for self-management of clinical conditions.	426	DC.2.2.4	1	N/C
						2. The system **SHALL** provide the ability to manage and/or develop patient guidance and reminders related to specific clinical conditions.	427	DC.2.2.4	2	N/C
						3. The system **SHOULD** conform to function DC.1.1.3.2 (Capture of Patient Originated Data).	428	DC.2.2.4	3	N/C
						4. The system **SHOULD** conform to function DC.1.3.1 (Manage Patient and Family Preferences).	429	DC.2.2.4	4	N/C
						5. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	430	DC.2.2.4	5	N/C
						6. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	431	DC.2.2.4	6	N/C

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DC.2.3	**H**	**EN**	Medication and Immunization Management			1. The system **SHALL** conform to function IN.1.9 (Patient Privacy and Confidentiality).	432	DC.2.3	1	N/C
						2. The system **SHALL** conform to function IN.2.2 (Auditable Records).	433	DC.2.3	2	N/C
						3. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	434	DC.2.3	3	N/C
DC.2.3.1	**H**	**EN**	Support for Medication and Immunization Ordering				435	DC.2.3.1		N/C
DC.2.3.1.1	**F**	**EN**	Support for Drug Interaction Checking	**Statement**: Identify drug interaction warnings time of medication ordering. **Description**: The clinician is alerted to drug-drug, drug-allergy, and drug-food interactions at levels appropriate to the health care setting and with respect to the patient condition. These alerts may be customized to suit the user or group. ~~If the patient's condition is one where, in order to view the necessary components of the health record, patient authorization or consent is required, then the system should show the medication but mask the condition for which the medication is prescribed until the required consent or authorization is available. In an emergent situation, where all health information is required to provide the most effective treatment, and it is not possible to obtain an authorization or consent, the system should provide an override function to allow access to the diagnosis or problem for which a medication was ordered. This may vary based on jurisdictional law~~.	S.3 IN.2.4 IN.6	1. The system **SHALL** check for and alert providers to interactions between prescribed drugs and medications on the current medication list.	436	DC.2.3.1.1	1	N/C
						2. The system **SHALL** relate medication allergies to medications to facilitate allergy checking decision support for medication orders.	437	DC.2.3.1.1	2	N/C
						3. The system **SHOULD** provide the ability to document that a provider was presented with and acknowledged a drug interaction warning.	438	DC.2.3.1.1	3	N/C
						4. The system **SHALL** provide the ability to prescribe a medication despite alerts for interactions and/or allergies being present.	439	DC.2.3.1.1	4	N/C
						5. The system **MAY** provide the ability to set the severity level at which warnings should be displayed.	440	DC.2.3.1.1	5	N/C
						6. The system ~~**SHOULD**~~ **SHALL** provide the ability to check for duplicate therapies.	441	DC.2.3.1.1	6	M

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						7. The system ~~**SHOULD**~~ **SHALL** conform to DC.1.8.6 (Manage Documentation of Clinician Response to Decision Support Prompts) and provide the ability to document why a drug interaction warning was overridden.	442	DC.2.3.1.1	7	M
						8. The system **MAY** check for interactions between prescribed drugs and food detailing changes in a drug's effects potentially caused by food (including beverages) consumed during the same time period.	443	DC.2.3.1.1	8	N/C
						9. The system **SHOULD** check for drug-lab interactions, to indicate to the prescriber that certain lab test results may be impacted by a patient's drugs.	444	DC.2.3.1.1	9	N/C
						10. The system **SHOULD** provide the ability to check medications against a list of drugs noted to be ineffective for the patient in the past.	445	DC.2.3.1.1	10	N/C
						11. The system **SHOULD** identify contraindications between a drug and patient conditions at the time of medication ordering.	446	DC.2.3.1.1	11	N/C
DC.2.3.1.2	**F**	**EN**	Support for Patient Specific Dosing and Warnings	**Statement**: Identify and present appropriate dose recommendations based on known patient~~-~~conditions and characteristics at the time of medication ordering. **Description**: The clinician is alerted to drug-condition interactions and patient specific contraindications and warnings such as ~~e.g. pregnancy, breast-feeding or occupational risks,~~ hepatic or renal insufficiency. The preferences of the	DC.2.3.1.1 IN.6	1. The system **SHALL** provide the ability to identify an appropriate drug dosage range, specific for each known patient condition (e.g., diagnosis) and parameter (e.g., height, weight, pulse, etc.) at the time of medication ordering.	447	DC.2.3.1.2	1	M
						2. The system **SHALL** provide the ability to automatically alert the provider if contraindications to the ordered dosage range are identified.	448	DC.2.3.1.2	2	N/C

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				patient may also be presented ~~e.g.~~ such as reluctance to use an antibiotic. Additional patient parameters, such as age, ~~gestation, Ht, Wt~~, height, weight, BSA, shall also be incorporated. While current versions of available standards and knowledge-bases may not fully support all requirements of this function, it is anticipated that these resources -- and therefore EHR systems -- will continue to evolve and support this function in an ever more robust fashion.		3. The system **SHALL** provide the ability for the provider to override a drug dosage warning.	449	DC.2.3.1.2	3	N/C
						4. The system ~~**SHOULD**~~ **SHALL** provide the ability to document reasons for overriding a drug alert or warning at the time of ordering.	450	DC.2.3.1.2	4	M
						5. The system ~~**SHOULD**~~ **SHALL** transmit documented reasons for overriding a drug alert to the pharmacy to enable communication between the clinician and the pharmacist.	451	DC.2.3.1.2	5	M
						5a. The system **SHOULD** transmit documented reasons for overriding a drug alert to the consulting pharmacist system (when available) to enable communication between the clinician and the consulting pharmacist.	452			A
						6. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	453	DC.2.3.1.2	6	N/C
						7. IF the maximum daily doses are known, THEN the system **SHALL** ~~apply~~ indicate the maximum dose per day in dosing decision support.	454	DC.2.3.1.2	7	M
						8. The system **SHOULD** compute drug doses, based on appropriate dosage ranges, using the patient's body weight.	455	DC.2.3.1.2	8	N/C
						9. The system **SHOULD** provide the ability to specify an alternative "dosing weight" for the purposes of dose calculation.	456	DC.2.3.1.2	9	N/C
						10. The system **SHOULD** perform drug dosage functions using any component of a combination drug (e.g., acetaminophen-hydrocodone).	457	DC.2.3.1.2	10	N/C

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						11. The system **SHOULD** provide the ability to ~~record~~ display the factors (e.g., lab values, weight, age, etc.) used to calculate the ~~future~~ dose for a given ~~prescription~~ order.	458	DC.2.3.1.2	11	M
DC.2.3.1.3	**F**	**EN**	Support for Medication Recommendations	**Statement**: The system should provide recommendations and options in medication and monitoring on the basis of patient diagnosis, cost, local formularies or therapeutic guidelines and protocols. **Description**: Offer alternative medications on the basis of practice standards (e.g., cost or adherence to guidelines), a generic brand, a different dosage, a different drug, or no drug (watchful waiting). Suggest lab order monitoring as indicated by the medication or the medical condition to be affected by the medication. Support expedited entry of series of medications that are part of a treatment regimen (i.e., renal dialysis, Oncology, transplant medications, etc.).	DC 2.3.1.2 S.3.3.2 IN.6	1. The system ~~**SHOULD**~~ **SHALL** conform to function DC 2.3.1.2 (Support for Patient-Specific Dosing and Warnings).	459	DC.2.3.1.3	1	M
						2. The system **SHOULD** present recommendations for medication regimens based on ~~findings related to~~ the patient diagnosis(es) (e.g., recommendations based on diagnoses in accordance with the Beers list).	460	DC.2.3.1.3	2	M
						3. The system **SHALL** present alternative treatments in medications on the basis of practice standards, cost, formularies, or protocols.	461	DC.2.3.1.3	3	N/C
						4. The system **SHOULD** present suggested ~~lab~~ monitoring (such as labs, behaviors, adverse reactions, side effects) as appropriate to a particular medication.	462	DC.2.3.1.3	4	M
						5. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	463	DC.2.3.1.3	5	N/C
DC.2.3.2	**F**	**EN**	Support for Medication and Immunization Administration	**Statement**: Alert providers to potential administration errors (such as wrong patient, wrong drug, wrong dose, wrong route and wrong time) in support of safe and accurate medication administration and support medication administration workflow. **Description**: To reduce medication errors at the time of administration of a	DC.1.3.3 DC.1.7.2 DC.1.10.1 DC.2.7.1 S.1.4.1 S.2.2.2	1. The system **SHALL** present information necessary to correctly identify the patient and accurately administer medications and immunizations such as ~~patient name~~, medication name, strength, dose, route and frequency, and patient name, patient photo, or other means of positive patient identification.	464	DC.2.3.2	1	M

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				medication, the patient is positively identified; checks on the drug, the dose, the route and the time are facilitated and appropriate alerts are provided at the point of care. 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. Access to drug monograph information may be provided to allow providers to check details about a drug and enhance patient education. Workflow for medication administration is supported through prompts and reminders regarding the "window" for timely administration of medications.	S.3.7.1 IN.2.3 IN.2.4 IN.6	2. The system **SHALL** alert providers to potential administration errors (such as wrong patient, wrong drug, wrong dose, wrong route and wrong time) as it relates to medication and immunizations administration.	465	DC.2.3.2	2	N/C
						3. The system ~~**SHOULD**~~ **SHALL** alert providers to potential medication administration errors at the point of medication administration.	466	DC.2.3.2	3	M
						4. The system **SHALL** provide the ability to capture all pertinent details of the medication administration including medication name, strength, dose, route, time of administration, exceptions to administration, and administrator of the medication.	467	DC.2.3.2	4	N/C
						5. ~~IF required by the EHR user's scope of practice, THEN~~ The system **SHALL** provide the ability to capture the administrator of the immunization and the immunization information identified in DC.1.8.2 (Manage Immunization Administration), Conformance Criteria #4 (The system SHALL provide the ability to capture immunization administration details, including date, type, lot number and manufacturer).	468	DC.2.3.2	5	M

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						6. ~~The system **MAY** generate documentation of medication or immunization administration as a by-product of verification of patient, medication, dose, route and time~~ IF the system has an electronic means for verification of patient, medication, dose, route and time THEN the system **SHALL** automatically capture the details of medication or immunization administration.	469	DC.2.3.2	6	M
						7. The system **SHOULD** prompt or remind providers regarding the date/time range for timely administration of medications.	470	DC.2.3.2	7	N/C
						8. The system **MAY** suggest alternative administration techniques based on age, developmental stage, weight, physiological status, mental status, educational level, and past physical history of the patient.	471	DC.2.3.2	8	N/C
						9. The system ~~**MAY**~~ **SHOULD** conform to function DC.2.7.1 (Access Healthcare Guidance) and provide ~~to~~ the ability for a provider to access drug monograph information.	472	DC.2.3.2	9	M
DC.2.4	**H**	**EN**	Orders, Referrals, Results and Care Management			1. The system **SHALL** conform to function IN.1.9 (Patient Privacy and Confidentiality).	473	DC.2.4	1	N/C
						2. The system **SHALL** conform to function IN.2.2 (Auditable Records).	474	DC.2.4	2	N/C
						3. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	475	DC.2.4	3	N/C
DC.2.4.1	**F**	**EN**	Create Order Set Templates	**Statement**: Create, capture, maintain and display order set templates based on patient data or preferred standards or other criteria.	DC.1.9.3 S.2.2.2	1. The system **SHALL** provide the ability to create order set templates.	476	DC.2.4.1	1	N/C

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				Description: Order set templates, which may include medication orders, allow a care provider to choose common orders for a particular circumstance or disease state according to standards or other criteria. Recommended order sets may be presented based on patient data or other contexts.	S.3.7.1 IN.1.1 IN.1.2 IN.1.3 IN.6	2. The system **SHALL** provide the ability to maintain order set templates, including version control.	477	DC.2.4.1	2	N/C
						3. The system ~~**MAY**~~ **SHOULD** provide the ability for providers to create individually customized order set templates ~~from provider input~~.	478	DC.2.4.1	3	M
						4. The system **MAY** capture order sets based on patient data that may be provided by the provider or that may be in accordance with preferred standards.	479	DC.2.4.1	4	N/C
						5. The system **MAY** provide the ability to create order set templates for ~~known~~ conditions ~~for a particular~~ or diseases.	480	DC.2.4.1	5	M
						6. The system **SHALL** present the order set templates to the provider.	481	DC.2.4.1	6	N/C
						7. The system **MAY** ~~record~~ provide the ability to capture the basis of the practice standards or criteria for the creation of the order set templates.	482	DC.2.4.1	7	M
						8. The system **MAY** provide the ability to ~~relate~~ present order set templates to providers based on diagnoses, conditions, or symptoms to aid decision support. ~~for certain diseases.~~	483	DC.2.4.1	8	M
						9. The system **SHALL** conform to DC.1.7.3 (Manage Order Sets).	484	DC.2.4.1	9	N/C
DC.2.4.2	**F**	**EN**	Support for Non-Medication Ordering	**Statement**: Display and request provider validation of information necessary for non-medication orders that make the order pertinent, relevant and resource-conservative at the time of provider order entry.	S.3.3.3 IN.6	1. The system **SHALL** identify required order entry components for non-medication orders.	485	DC.2.4.2	1	N/C
						2. The system **SHALL** present an alert at the time of order entry, if a non-medication order is missing required information.	486	DC.2.4.2	2	N/C

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				Description: Possible order entry support includes, but is not limited to: notification of missing results required for the order, suggested corollary orders, notification of duplicate orders, institution-specific order guidelines, guideline-based orders/order sets, order sets, order reference text, patient diagnosis specific recommendations pertaining to the order. Also, warnings for orders that may be inappropriate or contraindicated for specific patients (e.g., X-rays for pregnant women) are presented. Non-medication orders include orders such as: 1. DNR order 2. leave of absence 3. supplies such as 4x4's and ACE bandages 4. non-medical devices such as TTY phones for the hearing impaired 5. groups of supplies or kits common to an organization 6. simple durable medical equipment (DME) such as crutches or walkers 7. complex DME such as wheelchairs and hospital beds 8. therapies and other services that may require a referral and/or an authorization for insurance coverage		3. The system ~~**SHOULD**~~ **MAY** present an alert via warnings of orders that may be inappropriate or contraindicated for specific patients at the time of provider order entry.	487	DC.2.4.2	3	M
						4. The system **SHOULD** conform to function S.3.3.3. (Service Authorizations).	488	DC.2.4.2	4	N/C
DC.2.4.3	**F**	**EF 2012**	Support for Result Interpretation	**Statement**: Evaluate results and notify provider of results within the context of the patient's healthcare data. **Description**: Possible result interpretations include, but are not limited	S.2.2.2 S.3.7.1 IN.2.4 IN.6	1. The system **SHALL** present alerts for a result that is outside of a normal value range.	489	DC.2.4.3	1	N/C
						2. The system **SHOULD** provide the ability to trend results.	490	DC.2.4.3	2	N/C

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				to: abnormal result evaluation/ notification, trending of results (such as discrete lab values), evaluation of pertinent results at the time of provider order entry (such as evaluation of lab results at the time of ordering a radiology exam), evaluation of incoming results against active medication orders.		3. The system **MAY** provide the ability to evaluate pertinent results at the time of provider order entry (such as evaluation of lab results at the time of ordering a radiology exam).	491	DC.2.4.3	3	N/C
DC.2.4.4	**H**	**EN**	Support for Referrals				492	DC.2.4.4		N/C
DC.2.4.4.1	**F**	**EN**	Support for Referral Process	**Statement**: Evaluate referrals within the context of a patient's healthcare data. **Description**: When a healthcare referral is made, health information, including pertinent clinical and behavioral health results, demographic and insurance data elements (or lack thereof) are presented to the provider. Standardized or evidence based protocols for appropriate workup prior to referral may be presented.	S.1.3.1a S.1.3.5 S.2.2.2 S.3.3.2 IN.2.4 IN.6	1. The system **SHALL** provide the ability to include clinical and administrative data (e.g., insurance information) as part of the referral process.	493	DC.2.4.4.1	1	N/C
						2. The system **SHALL** provide the ability to include test and procedure results with a referral.	494	DC.2.4.4.1	2	N/C
						3. The system **MAY** provide the ability to include standardized or evidence based protocols with the referral.	495	DC.2.4.4.1	3	N/C
						4. The system **SHOULD** allow clinical, administrative data, and test and procedure results to be transmitted to the referral clinician or clinical setting.	496	DC.2.4.4.1	4	M
						5. The system **SHALL** conform to function S.2.2.1 (Health Record Output).	497	DC.2.4.4.1	5	N/C
DC.2.4.4.2	**F**	**O**	Support for Referral Recommendations	**Statement**: Evaluate patient data and recommend that a patient be referred based on the specific patient's healthcare data.	S.3.7.1 IN.6	1. The system **SHALL** present recommendations for potential referrals based on diagnosis(es).	498	DC.2.4.4.2	1	N/C

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				Description: Entry of specific patient conditions may lead to recommendations for referral (e.g., ~~for smoking cessation counseling if the patient is prescribed a medication to support cessation screening or assessment for behavioral health conditions~~ diagnosis of depression recommends referral to psychologist).		2. The system **SHALL** present recommendations for potential referrals based on patient condition (e.g. ~~for smoking cessation counseling if the patient is prescribed a medication to support cessation~~ conditions triggered from MDS such as declining ADL's, vision or hearing problems, abnormal lab values, recommendation for medication evaluation, etc.).	499	DC.2.4.4.2	2	M
						3. The system **SHOULD** conform to IN.1.4 (Patient Access Management).	500	DC.2.4.4.2	3	N/C
DC.2.4.5	**H**	**O**	Support for Care Delivery				501	DC.2.4.5		N/C
DC.2.4.5.1	**F**	**O**	Support for Safe Blood Administration	**Statement**: Provide checking in real-time for potential blood administration errors. **Description**: To reduce errors at the time of blood product administration, the patient is positively identified. Additionally, checks on blood product identification, amount to be delivered, route and time of administration are captured, and alerts are provided as appropriate.	DC.1.10.2 S.1.2 S.2.2.1 IN.6	1. The system **SHALL** present information necessary to correctly identify the patient and accurately administer blood products including patient name, blood product number, amount, route, product expiration date and time of administration.	502	DC.2.4.5.1	1	N/C
						2. The system **SHALL** capture validation of the correct matching of the patient to the blood product.	503	DC.2.4.5.1	2	N/C
						3. The system **SHALL** capture the blood product number, amount, route and time of administration.	504	DC.2.4.5.1	3	N/C
						4. The system **SHALL** conform to function DC.1.8.4 (Manage Patient Clinical Measurements) and capture the blood pressure, temperature, pulse, respirations of the patient receiving the product.	505	DC.2.4.5.1	4	N/C
						5. The system **SHALL** conform to function S.2.2.1 (Health Record Output).	506	DC.2.4.5.1	5	N/C

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DC.2.4.5.2	**F**	**O**	Support for Accurate Specimen Collection	**Statement**: Provide checking to ensure accurate specimen collection is supported. **Description**: To ensure the accuracy of specimen collection, the patient and specimen are positively identified. The provider is notified in real-time of potential collection errors such as wrong patient, wrong specimen type, wrong means of collection, wrong site, and wrong date and time.	S.1.4.1 S.2.2.1 IN.1.6 IN.1.7 IN.1.9 IN.2.3 IN.2.4 IN.6	1. The system **SHALL** provide the ability to present information necessary to correctly identify the patient and accurately identify the specimen to be collected including, but not limited to, patient name, specimen type, specimen source, means of collection, date and time.	507	DC.2.4.5.2	1	N/C
						2. The system **SHALL** report variation between the type of specimen order placed and actual specimen received.	508	DC.2.4.5.2	2	N/C
						3. The system **SHALL** capture the details of specimen collection.	509	DC.2.4.5.2	3	N/C
						4. The system **SHALL** conform to function S.2.2.1 (Health Record Output).	510	DC.2.4.5.2	4	N/C
						5. The system **SHOULD** notify the provider in real-time of a variation between the type of specimen order placed and the actual specimen received.	511	DC.2.4.5.2	5	N/C
DC.2.5	**H**	**O**	Support for Health Maintenance: Preventive Care and Wellness			1. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	512	DC.2.5	1	N/C
						2. The system **SHALL** conform to function IN.1.9 (Patient Privacy and Confidentiality).	513	DC.2.5	2	N/C
						3. The system **SHALL** conform to function IN.2.2 (Auditable Records).	514	DC.2.5	3	N/C
						4. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	515	DC.2.5	4	N/C
DC.2.5.1	**F**	**O**	Present Alerts for Preventive Services and Wellness	**Statement**: At the point of clinical decision making, identify patient specific suggestions/reminders, screening tests/exams, and other preventive services in support of routine preventive and wellness patient care standards.	DC.2.5.1 DC.2.5.2 DC.2.6.2 IN.6	1. The system **SHALL** provide the ability to establish criteria for the identification of preventive care and wellness services based on patient demographics (e.g., age, gender).	516	DC.2.5.1	1	N/C

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				Description: At the time of an encounter, the provider or patient is presented with due or overdue activities based on protocols for preventive care and wellness. Examples include but are not limited to, routine immunizations, ~~adult and well child care, age and gender appropriate screening exams, such as PAP smears~~ screening such as mammograms and prostate cancer checks, colonoscopy, etc. The provider may wish to provide reminders to the patient based on the alert.		2. The system ~~**SHOULD**~~ **SHALL** provide the ability to modify the established criteria that trigger the alerts.	517	DC.2.5.1	2	M
						3. The system **SHOULD** present recommended preventative or wellness services needed based upon clinical test results.	518	DC.2.5.1	3	N/C
						4. The system **SHALL** present alerts to the provider of all patient specific preventive services that are due.	519	DC.2.5.1	4	N/C
						5. The system **MAY** provide the ability to produce a list of all alerts along with the scheduled date and time for the preventive service.	520	DC.2.5.1	5	N/C
						6. The system **MAY** provide the ability to produce a history of all alerts that were generated for the patient in the record.	521	DC.2.5.1	6	N/C
DC.2.5.2	**F**	**N/A**	~~Notifications and Reminders for Preventive Services and Wellness~~	~~**Statement**: Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.~~ ~~**Description**: The provider can generate notifications to patients regarding activities that are due or overdue and these communications can be captured. Examples include but are not limited to time sensitive patient and provider notification of: follow-up appointments, laboratory tests, immunizations or examinations. The notifications can be customized in terms of timing, repetitions and administration reports. E.g. a PAP test reminder might be sent to the patient two months prior to the test being due, repeated at three month intervals, and then reported to the administrator or clinician when nine months overdue.~~	~~S.3.7.2~~ ~~S.3.7.4~~ ~~IN.6~~	~~1. The system **SHOULD** generate timely notifications to patients including services, tests or actions that are due or overdue.~~	522	DC.2.5.2	1	D
						~~2. The system **SHOULD** capture a history of notifications.~~	523	DC.2.5.2	2	D
						~~3. The system **SHOULD** provide the ability to track overdue preventive services.~~	524	DC.2.5.2	3	D
						~~4. The system **SHOULD** provide notification of overdue preventative services in the patient record.~~	525	DC.2.5.2	4	D
						~~5. The system **MAY** provide the ability to configure patient notifications (such as repetitions or timing of the activity).~~	526	DC.2.5.2	5	D
						~~6. The system **SHOULD** provide the ability to update content of notifications, guidelines, reminders and associated reference materials.~~	527	DC.2.5.2	6	D

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						~~7. The system **MAY** provide the ability to manage the lifecycle of the states of the notifications and reminders.~~	528	DC.2.5.2	7	D
DC.2.6	**H**	**EF 2011**	Support for Population Health			1. The system **SHALL** conform to function IN.1.9 (Patient Privacy and Confidentiality).	529	DC.2.6	1	N/C
						2. The system **SHALL** conform to function IN.2.2 (Auditable Records).	530	DC.2.6	2	N/C
DC.2.6.1	**F**	**O**	Support for Epidemiological Investigations of Clinical Health Within a Population	**Statement**: Support internal and external epidemiological investigations of clinical health of aggregate patient data for use in identifying health risks from the environment and/or population in accordance with jurisdictional law. **Description**: Standardized surveillance performance measures that are based on known patterns of disease presentation can be identified by aggregating data from multiple input mechanisms. For example, elements include, but are not limited to patient demographics, resource utilization, presenting symptoms, acute treatment regimens, laboratory and imaging study orders and results and genomic and proteomic data elements. Identification of known patterns of existing diseases involves aggregation and analysis of these data elements by existing relationships. However, the identification of new patterns of disease requires more sophisticated pattern recognition analysis. Early recognition of new	S.1.5 S.2.1.1 S.2.1.2 S.2.2.2 S.2.2.3 IN.1.6 IN.1.9 IN.2.2 IN.2.3 IN.2.4	1. The system **SHALL** provide the ability to aggregate patient information based on user-identified criteria.	531	DC.2.6.1	1	N/C
						2. The system **SHALL** apply local privacy and confidentially rules when assembling aggregate data to prevent identification of individuals by unauthorized parties.	532	DC.2.6.1	2	N/C
						3. The system **SHOULD** provide the ability to use ~~any~~ demographic or clinical information as criteria for aggregation.	533	DC.2.6.1	3	M
						4. The system **SHOULD** present aggregate data in the form of reports for external use.	534	DC.2.6.1	4	N/C
						5. The system **SHOULD** provide the ability to save report definitions for later use.	535	DC.2.6.1	5	N/C
						6. The system **MAY** present aggregate data in an electronic format for use by other analytical programs.	536	DC.2.6.1	6	N/C
						7. The system **MAY** provide the ability to derive statistical information from aggregate data.	537	DC.2.6.1	7	N/C

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				patterns requires data points available early in the disease presentation. Demographics, ordering patterns and resource use (e.g., ventilator or intensive care utilization pattern changes) are often available earlier in the presentation of non-predictable diseases. Consumer-generated information is also valuable with respect to surveillance efforts.		8. IF biosurveillance or other epidemiological investigations require standardized transmission of data to/from a registry or directory, THEN the system **SHALL** conform to function IN.3 (Registry and Directory Services).	538	DC.2.6.1	8	N/C
DC.2.6.2	**F**	**EF 2011**	Support for Notification and Response	**Statement**: Upon notification by an external, authoritative source of a health risk within the cared for population, alert relevant providers regarding specific potentially at-risk patients with the appropriate level of notification. **Description**: After receiving a notice of a health risk within a cared-for population from public health authorities or other external authoritative sources: 1. Identify and notify individual care providers or care managers that a risk has been identified and requires attention; and 2. Provide suggestions on the appropriate course of action. A care provider now has the ability to decide how patients are notified, if necessary. For example, this function may be used after detection of a local outbreak of hepatitis A, advising providers of the at-risk population and potential prophylactic treatment.	S.1.3.6 S.2.2.2 S.3.7.1 S.3.7.4 IN.1.6 IN.1.7 IN.2.4 IN.3.1 IN.3.2 IN.4.1 IN.4.2 IN.4.3 IN.5.1 IN.5.2 IN.5.4	1. The system **SHALL** provide the ability to identify individual care providers or care managers within ~~a cared for population~~ the facility.	539	DC.2.6.2	1	M
						2. The system **SHALL** provide the ability to prepare a response notification to the care providers or care managers.	540	DC.2.6.2	2	N/C
						3. The system **SHALL** provide the ability to capture notification of a health risk within ~~a cared for~~ the resident/patient population from public health authorities or other external authoritative sources as either free-text or a structured message (or by other means).	541	DC.2.6.2	3	M
						4. The system **SHOULD** provide the ability to coordinate with local and national programs to disseminate notifications of health risk to individual care providers or care-managers within the facility.	542	DC.2.6.2	4	M
						5. The system **MAY** provide the ability to notify patients, directly or indirectly, who are described by the health risk alert.	543	DC.2.6.2	5	N/C
						6. The system ~~**SHOULD**~~ **MAY** present suggestions to the care provider indicating an appropriate course of action.	544	DC.2.6.2	6	M

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				A second example might be the dissemination of new care guidelines for elderly patients with a specific chronic disease. Notifications to clinicians or patients may occur by telephone, email, FAX or other methods.		7. The system **SHALL** provide the ability to notify public health authorities or other external authoritative sources of a health risk within ~~a cared for~~ the resident/patient population in accordance with scope of practice, organizational policy and jurisdictional law.	545	DC.2.6.2	7	M
						8. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	546	DC.2.6.2	8	N/C
DC.2.6.3	**F**	**EF 2011**	Support for Monitoring Response Notifications Regarding a Specific Patient's Health	**Statement**: In the event of a health risk alert and subsequent notification related to a specific patient, monitor if expected actions have been taken, and execute follow-up notification if they have not. **Description**: Identifies that expected follow-up for a specific patient event (e.g., follow up to error alerts or absence of an expected lab result) has not occurred and communicate the omission to appropriate care providers in the chain of authority. The notification process requires a security infrastructure that provides the ability to match a care provider's clinical privileges with the clinical requirements of the notification.	DC.1.6.1 DC.1.6.2 S.1.3.6 S.1.4.1 S.2.2.2 S.2.2.3 S.3.7.4 IN.2.4 IN.6	1. The system **SHALL** present specific actions to be taken at the patient level for a health risk alert.	547	DC.2.6.3	1	N/C
						2. The system **SHALL** notify appropriate care providers of specific patient actions required by a health risk alert.	548	DC.2.6.3	2	N/C
						3. The system **SHALL** provide the ability to identify those patients who have not received appropriate action in response to a health risk alert.	549	DC.2.6.3	3	N/C
						4. The system **SHOULD** provide the ability to produce a report on the omission of an appropriate response to the health risk alert in specific patients.	550	DC.2.6.3	4	M
						5. The system ~~**SHOULD**~~ **MAY** conform to function IN.1.4 (Patient Access Management).	551	DC.2.6.3	5	M
						6. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	552	DC.2.6.3	6	N/C
DC.2.7	**H**	**EF 2011**	Support for Knowledge Access			1. The system **SHOULD** conform to function IN.3 (Registry and Directory Services)	553	DC.2.7	1	N/C

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DC.2.7.1	**F**	**EF 2011**	Access Healthcare Guidance	**Statement**: Provide pertinent information from available evidence-based knowledge, at the point of care, for use in healthcare decisions and care planning. **Description**: The information available regarding disease, disease processes, diagnostic testing, pharmaceuticals, treatment patterns and all aspects of healthcare is constantly changing. The practitioner should be able to access a wide variety of sources that provide relevant, accurate information about any given subject. Examples of resources include, but are not limited to: evidence on treatment of specific medical conditions, maintenance of wellness, drug or device trials, context-specific information available through online journals, printed resources such as books and specialty organizations resources. For example, when a condition is diagnosed the provider might be directed to relevant resources that give updated clinical research, useful pharmaceutical combinations, surgical techniques, products or other information useful in the management of the specific condition under consideration.	S.3.7.1 S.3.7.4 IN.5.1 IN.5.2 IN.5.3 IN.5.4 IN.6	1. The system **SHALL** provide the ability to access evidence-based healthcare recommendations, with documentation of sources	554	DC.2.7.1	1	N/C
						2. The system ~~**SHOULD**~~ **SHALL** provide the ability to access evidenced-based documentation appropriate for the care provider to render a timely judgment.	555	DC.2.7.1	2	M
						3. The system ~~**MAY**~~ **SHOULD** provide the ability to access external evidence-based documentation.	556	DC.2.7.1	3	M
						4. The system **SHALL** conform to function DC.2.2.1.1 (Support for Standard Care Plans, Guidelines, Protocols).	557	DC.2.7.1	4	N/C
						5. The system **SHOULD** conform to function IN.1.4 (Patient Access Management).	558	DC.2.7.1	5	N/C
DC.2.7.2	**F**	**EF 2012**	Patient Knowledge Access	**Statement**: Provide the ability to access reliable information about wellness, disease management, treatments, peer support groups and related information that is relevant for a specific patient. **Description**: An individual will be able to find reliable information to research a health question, follow up from a clinical visit, identify treatment options, or other health information needs. The	DC.3.2.4 DC.3.4.9 S.3.7.1 S.3.7.2 S.3.7.4 IN.1.4 IN.5.1	1. The system **SHALL** provide the ability to access information about wellness, disease management, treatments, and related information that is relevant for a specific patient.	559	DC.2.7.2	1	N/C
						2. The system **MAY** provide the ability to access information related to a health question directly from data in the health record or other means such as key word search.	560	DC.2.7.2	2	N/C

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				information may be linked directly from entries in the health record, or may be accessed through other means such as key word search. The information may be provided as part of the EHR system but may also include patient information from external databases or specific websites.	IN.5.3 IN.5.4 IN.6	3. The system **MAY** provide the ability to access patient educational information from external sources.	561	DC.2. 7.2	3	N/C
						4. IF the information is external-based, THEN the system **MAY** provide the ability to identify links specific to the information.	562	DC.2. 7.2	4	N/C
						5. The system **SHALL** conform to function IN.1.4 (Patient Access Management).	563	DC.2. 7.2	5	N/C
						6. The system **SHALL** conform to function IN.1.9 (Patient Privacy and Confidentiality).	564	DC.2. 7.2	6	N/C
						7. The system **SHALL** conform to function IN.2.2 (Auditable Records).	565	DC.2. 7.2	7	N/C
DC.3	**H**	**EN**	**Operations Management and Communication**			1. The system **SHALL** conform to function IN.1.1 (Entity Authentication).	566	DC.3	1	N/C
						2. The system **SHALL** conform to function IN.1.2 (Entity Authorization).	567	DC.3	2	N/C
						3. The system **SHALL** conform to function IN.1.3 (Entity Access Control).	568	DC.3	3	N/C
						4. IF the system exchanges data across entity boundaries within an EHR-S or external to an EHR-S, THEN the system **SHALL** conform to function IN.1.6 (Secure Data Exchange) to ensure that the data are protected.	569	DC.3	4	N/C
						5. IF the system exchanges data with other sources or destinations of data, THEN the system **SHALL** conform to Function IN.1.~~7~~ 10 (Secure Data Routing -LTC), to ensure that the exchange occurs only among authorized senders and "receivers".	570	DC.3	5	M

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						6. IF the system is used to enter or modify data in the health record, THEN the system **SHALL** conform to function IN.1.8 (Information Attestation) to show authorship and responsibility for the data.	571	DC.3	6	N/C
						7. The system **SHALL** conform to function IN.1.9 (Patient Privacy and Confidentiality).	572	DC.3	7	N/C
						8. The system **SHALL** conform to function IN.2.1 (Data Retention, Availability and Destruction).	573	DC.3	8	N/C
						9. The system **SHALL** conform to function IN.2.2 (Auditable Records).	574	DC.3	9	N/C
						10. The system **SHOULD** conform to function IN.2.3 (Synchronization).	575	DC.3	10	N/C
						11. IF the system is used to extract data for analysis and reporting, THEN the system **SHALL** conform to function IN.2.4 (Extraction of Health Record Information) to support data extraction across the complete health record of an individual.	576	DC.3	11	N/C
						12. IF the system stores unstructured data, THEN the system **SHALL** conform to function IN.2.5.1, (Manage Unstructured Health Record Information), to ensure data integrity through all changes.	577	DC.3	12	N/C
						13. IF the system stores structured data, THEN the system **SHALL** conform to function IN.2.5.2 (Manage Structured Health Record Information) to ensure data integrity through all changes.	578	DC.3	13	N/C

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						14. IF the system processes data for which generally accepted standard terminologies have been established, THEN the system **SHALL** conform to function IN.4.1 (Standard Terminologies and Terminology Models) to support semantic interoperability.	579	DC.3	14	N/C
						15. IF the system processes data for which generally accepted standard terminologies have been established, THEN the system **SHALL** conform to function IN.4.2 (Maintenance and Versioning of Standard Terminologies) to preserve the semantics of coded data over time.	580	DC.3	15	N/C
						16. The system **SHOULD** conform to function IN.4.3 (Terminology Mapping).	581	DC.3	16	N/C
						17. IF the system exchanges data for which generally accepted interchange standards have been established, THEN the system **SHALL** conform to function IN.5.1 (Interchange Standards) to support interoperability.	582	DC.3	17	N/C
						18. IF the system exchanges data for which generally accepted interchange standards have been established, THEN the system **SHALL** conform to function IN.5.2 (Interchange Standards Versioning and Maintenance) to accommodate the inevitable evolution of interchange standards.	583	DC.3	18	N/C
						19. The system **SHOULD** conform to function IN.5.3 (Standards-based Application Integration).	584	DC.3	19	N/C

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						20. IF the system exchanges data with other systems outside itself, THEN the system **SHALL** conform to function IN.5.4 (Interchange Agreements) to define how the sender and receiver will exchange data.	585	DC.3	20	N/C
						21. The system **SHOULD** conform to function IN.6 (Business Rules Management).	586	DC.3	21	N/C
						22. The system **SHOULD** conform to function IN.7 (Workflow Management).	587	DC.3	22	N/C
DC.3.1	**H**	**EN**	Clinical Workflow Tasking	**Statement**: Schedule and manage tasks with appropriate timeliness. **Description**: Since the electronic health record will replace the paper chart, tasks that were based on the paper artifact must be effectively managed in the electronic environment. Functions must exist in the EHR-S that support electronically any workflow that previously depended on the existence of a physical artifact (such as the paper chart, a phone message slip) in a paper based system. Tasks differ from other more generic communication among participants in the care process because they are a call to action and target completion of a specific workflow in the context of a patient's health record (including a specific component of the record). Tasks also require disposition (final resolution). The initiator may optionally require a response. For example, in a paper based system, physically placing charts in piles for review creates a physical queue of tasks related to those charts. This queue of tasks (for example, a set of patient			588	DC.3.1		N/C

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				phone calls to be returned) must be supported electronically so that the list (of patients to be called) is visible to the appropriate user or role for disposition. Tasks are time-limited (or finite). The state transition (e.g., created, performed and resolved) may be managed by the user explicitly or automatically based on rules. For example, if a user has a task to signoff on a test result, that task should automatically be marked complete by the EHR when the test result linked to the task is signed in the system. Patients will become more involved in the care process by receiving tasks related to their care. Examples of patient related tasks include acknowledgement of receipt of a test result forwarded from the provider, or a request to schedule an appointment for a pap smear (based on age and frequency criteria) generated automatically by the EHR-S on behalf of the provider.						
DC.3.1.1	**F**	**EN**	Clinical Task Assignment and Routing	**Statement**: Assignment, delegation and/or transmission of tasks to the appropriate parties. **Description**: Tasks are at all times assigned to at least one user or role for disposition. Whether the task is assignable and to whom the task can be assigned will be determined by the specific needs of practitioners in a care setting. Task-assignment lists help users prioritize and complete assigned tasks. For example, after receiving communication (e.g. a phone call or e-mail) from a ~~patient, the triage nurse~~	S.1.3.1a S.1.3.5 IN.6	1. The system **SHALL** provide the ability for users to create manual clinical tasks.	589	DC.3.1.1	1	N/C
						2. The system **SHALL** provide the ability to automate clinical task creation.	590	DC.3.1.1	2	N/C
						3. The system **SHALL** provide the ability to manually modify and update task status (e.g., created, performed, held, canceled, pended, denied, and resolved).	591	DC.3.1.1	3	N/C
						4. The system ~~**MAY**~~ **SHOULD** provide the ability to automatically modify or update the status of tasks based on workflow rules.	592	DC.3.1.1	4	M

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				~~routes or assigns a task to return the patient's call to the physician who is on call~~ physician for a urinalysis, the nurse routes or assigns a task to clinical staff to collect a urine specimen. Task creation and assignment may be automated, where appropriate. An example of a system-triggered task is when lab results are received electronically; a task to review the result is automatically generated and assigned to a clinician. Task assignment ensures that all tasks are disposed of by the appropriate person or role and allows efficient interaction of entities in the care process.		5. The system **SHOULD** provide the ability to assign, and change the assignment of, tasks to individuals or to clinical roles.	593	DC.3.1.1	5	N/C
						6. The system ~~**MAY**~~ **SHOULD** provide the ability to manage workflow task routing to multiple individuals or roles in succession and/or in parallel.	594	DC.3.1.1	6	M
						7. The system ~~**MAY**~~ **SHOULD** provide the ability to prioritize tasks based on urgency assigned to the task.	595	DC.3.1.1	7	M
						8. The system ~~**MAY**~~ **SHOULD** provide the ability to restrict task assignment based on appropriate role as defined by the entity.	596	DC.3.1.1	8	M
						8a. The system **MAY** provide the ability to restrict task assignment based on an individual as defined by the entity.	597			A
						9. The system ~~**MAY**~~ **SHOULD** provide the ability to escalate clinical tasks manually or per business rules as appropriate to ensure timely completion.	598	DC.3.1.1	9	M
						10. IF the system is used to enter, modify, or exchange data, THEN the system **SHALL** conform to IN.1.5 (Non-Repudiation) to guarantee that the sources and receivers of data cannot deny that they entered/modified/sent/received the data.	599	DC.3.1.1	10	M
						11. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	600	DC.3.1.1	11	N/C

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DC.3.1.2	**F**	**EN**	Clinical Task Linking	**Statement**: Linkage of tasks to patients and/or a relevant part of the electronic health record. **Description**: Clinical tasks must include information or provide an electronic link to information that is required to complete the task. For example, this may include a patient location in a facility, a ~~patient's~~ family's contact information, or a link to new lab results in the patient's EHR. An example of a well defined task is "Dr. Jones must review Mr. Smith's blood work results." Efficient workflow is facilitated by navigating to the appropriate area of the record to ensure that the appropriate test result for the correct patient is reviewed. Other examples of tasks might involve fulfillment of orders or responding to ~~patient~~ family phone calls.	S.1.3.1 S.1.4.1 S.1.4.2 S.1.4.4 S.1.6 S.1.7 IN.2.3 IN.7	1. The system **SHALL** provide the ability to link a clinical task to the component of the EHR required to complete the task (e.g., a task to take weights links to the 'Weights and Vitals' screen to record the result; a task to complete a Fall assessment links to the Fall assessment form to be completed; the weekly task to perform skin checks links to the documentation template for skin assessment).	601	DC.3.1.2	1	M
						2. The system **SHALL** conform to function IN.1.5 (Non-Repudiation).	602	DC.3.1.2	2	N/C
DC.3.1.3	**F**	**EN**	Clinical Task Tracking	**Statement**: Track tasks to facilitate monitoring for timely and appropriate completion of each task. **Description**: In order to reduce the risk of errors during the care process due to missed tasks, the provider is able to view and track un-disposed tasks, current work lists, the status of each task, unassigned tasks or other tasks where a risk of omission exists. The timeliness of certain tasks can be tracked, or reports generated, in accordance with relevant law and accreditation standards. For example, a provider is able to create a report ~~to stow test results that have not~~	S.2.2.2 S.2.2.3 IN.2.4 IN.7	1. The system **SHALL** provide the ability to track the status of tasks.	603	DC.3.1.3	1	N/C
						2. The system **SHALL** provide the ability to notify providers of the status of tasks.	604	DC.3.1.3	2	N/C
						3. The system ~~**SHOULD**~~ **SHALL** provide the ability to sort clinical tasks by status.	605	DC.3.1.3	3	M
						4. The system ~~**MAY**~~ **SHOULD** provide the ability to present current clinical tasks as work lists.	606	DC.3.1.3	4	M
						5. The system **SHOULD** provide the ability to ~~define the presentation of~~ sort or filter clinical task lists presented in reports or on the screen.	607	DC.3.1.3	5	M

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				~~been reviewed by the ordering provider based on an interval appropriate to the care setting~~ that shows tests that have not yet been performed such as urine specimen obtained, blood work drawn, etc.		6. IF the system is used to enter, modify, or exchange data, THEN the system **SHALL** conform to IN.1.5 (Non-Repudiation) to guarantee that the sources and receivers of data cannot deny that they entered/modified/sent/received the data.	608	DC.3.1.3	6	M
						7. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	609	DC.3.1.3	7	N/C
DC.3.2	**H**	**EN**	Support Clinical Communication	**Statement**: **Description**: Health care requires secure communications among various participants: patients, doctors, nurses, chronic disease care managers, pharmacies, laboratories, payers, consultants, and etc. An effective EHRS supports communication across all relevant participants, reduces the overhead and costs of healthcare-related communications, and provides automatic tracking and reporting. The list of communication participants is determined by the care setting and may change over time. Because of concerns about scalability of the specification over time, communication participants for all care settings or across care settings are not enumerated here because it would limit the possibilities available to each care setting and implementation. However, communication between providers and between patients and providers will be supported in all appropriate care settings and across care settings. Implementation of the EHRS enables new and more effective channels of communication, significantly improving efficiency and patient care.		1. The system **SHOULD** conform to function IN.3 (Registry and Directory Services).	610	DC.3.2	1	N/C

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				The communication functions of the EHRS will eventually change the way participants collaborate and distribute the work of patient care.						
DC.3.2.1	**F**	**EN**	Support for Inter-Provider Communication	**Statement**: Support exchange of information between providers as part of the patient care process, and the appropriate documentation of such exchanges. Support secure communication to protect the privacy of information as required by federal or jurisdictional law. **Description**: Communication among providers involved in the care process can range from real time communication (for example, ~~fulfillment of an injection while the patient is in the exam room~~, communication between a therapist and nurse), to asynchronous communication (for example, consult reports between physicians). Some forms of inter-practitioner communication will be paper based and the EHR-S must be able to produce appropriate documents. The system should provide for both verbal and written communication. These exchanges would include, but not be limited to, consults and referrals as well as possible exchanges within the office as part of the provision and administration of patient care (for example, the communication of new	DC.1.1.3 DC.1.9.5 S.1.3.1a S.1.3.2 S.1.3.3 S.1.3.4 S.2.2.2 IN.1.5 IN.1.6 IN.1.7 IN.1.9 IN.2.2. IN.3.1 IN.5.1 IN.5.2	1. The system **SHALL** provide the ability to document in the patient record verbal/telephone communication between providers.	611	DC.3.2.1	1	N/C
						2. The system **SHALL** provide the ability to incorporate scanned documents from ~~external~~ providers into the patient record.	612	DC.3.2.1	2	M
						3. The system ~~**MAY**~~ **SHOULD** provide the ability to communicate using real-time messaging.	613	DC.3.2.1	3	M
						4. The system **SHOULD** provide the ability to communicate clinical information (e.g. referrals) via secure e-mail or other electronic means (such as a CCD).	614	DC.3.2.1	4	M
						5. The system **MAY** provide the ability to transmit electronic multi-media data types representing pictures, sound clips, or video as part of the patient record.	615	DC.3.2.1	5	N/C

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				information obtained within the office environment during the process of administration of a tetanus shot while the patient is in the exam room). The system should support the creation and acceptance of paper artifacts where appropriate.		6. The system **SHALL** conform to function IN.1.5 (Non-Repudiation).	616	DC.3.2.1	6	N/C
DC.3.2.2	**F**	**EN**	Support for Provider - Pharmacy Communication	**Statement**: Provide features to enable secure bi-directional communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders. **Description**: When a medication is prescribed, the order is routed to the pharmacy or other intended recipient of pharmacy orders. This information is used to avoid transcription errors and facilitate detection of potential adverse reactions. If there is a question from the pharmacy, that communication can be presented to the provider with their other tasks. In the nursing facility, medication order creation is a collaborative process involving the prescriber and facility staff. Accordingly, this function applies to communication process between the prescriber, facility and the pharmacy or other intended recipient of pharmacy orders. ~~The transmission of prescription data between systems should conform to realm acceptable messaging standards.~~	S.3.7.1 IN.1.5 IN.1.6 IN.1.7 IN.1.9 IN.2.2 IN.3.1 IN.4.1 IN.4.2 IN.4.3 IN.5.1 IN.5.2 IN.5.3 IN.5.4 IN.6 IN.7	1. The system **SHALL** conform to function DC.1.7.1 (Manage Medication Orders) and provide the ability to order medications.	617	DC.3.2.2	1	N/C
						1a. The system **SHALL** conform to function IN.5.1 (Interchange Standards).	618			A
						2. The system **SHALL** electronically communicate orders between the prescriber/~~provider~~ facility and pharmacy, as necessary, to initiate, change, or renew a medication order.	619	DC.3.2.2	2	M
						2a. The system **SHOULD** provide the ability to communicate a request to the pharmacy (based on an existing order) that additional medication be delivered (i.e., re-supply request).	620			A
						3. The system **SHALL** receive any acknowledgements, prior authorizations, renewals, inquiries and fill notifications provided by the pharmacy or other participants in the electronic prescription and make it available for entry in the patient record.	621	DC.3.2.2	3	N/C
						4. ~~The system **SHOULD** provide the ability to electronically communicate current realm-specific standards to pharmacies.~~	622	DC.3.2.2	4	D

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				~~As an example, specific standards in the United States include the most recent versions of criteria from Health Level 7 (HL7), X12N, and/or the National Council for Prescription Drug Programs (NCPDP); and those of the National Electronic Claims Standard (NeCST) in Canada. It is anticipated that other realms may list other acceptable messaging standards~~. As required in IN.5.1 (Interchange Standards), transmission of prescription data between a facility and pharmacy that are not part of the same legal entity shall conform to NCPDP SCRIPT version 10.2 or higher. If the facility and pharmacy exchanging electronic prescription data are part of the same legal entity, IN.5.1 (Interchange Standards) supports the use of HL7 messaging or NCPDP SCRIPT version 10.2 or higher.		4a. The system **SHALL** have the ability to indicate that a NCPDP SCRIPT message has been sent or received, and display that message in human readable form.	623			A
						4b. The system **SHOULD** have the ability to exchange Drug Utilization Review (DUR) findings and Formulary & Benefits (F&B) data with the pharmacy using NCPDP SCRIPT (version 10.2 or higher).	624			A
						4c. The system **SHOULD** have the ability to notify the user when an NCPDP SCRIPT message has been received from an external source (such as pharmacy or prescriber).	625			A
						5. The system **MAY** provide the ability for providers and pharmacies to communicate clinical information via secure e-mail or other electronic means, on both general and specific orders.	626	DC.3.2.2	5	M
						6. The system ~~**MAY** provide the ability to use secure~~ **SHALL** transmit prescription messages in real-time. ~~messaging.~~	627	DC.3.2.2	6	M
						7. The system **MAY** provide the ability to include workflow tasks as part of communication to the provider.	628	DC.3.2.2	7	N/C
						8. IF the system is used to enter, modify, or exchange data, THEN the system **SHALL** conform to IN.1.5 (Non-Repudiation) to guarantee that the sources and receivers of data cannot deny that they entered/modified/sent/received the data.	629	DC.3.2.2	8	M

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DC.3.2.3	**F**	**EN**	Support for Communications Between Provider and Patient and/or the Patient Representative	**Statement**: Facilitate communications between providers and patients and/or the patient representatives. **Description**: Providers are able to communicate with patients and others, capturing the nature and content of electronic communication, or the time and details of other communication. The "capture of communication" can be in the form of progress notes that are designated as "communication" or through automated processes. Examples: • ~~When test results arrive, the clinician may wish to email the patient that test result was normal (details of this communication are captured).~~ • ~~A patient may wish to request a refill of medication by emailing the physician.~~ • ~~Patients with asthma may wish to communicate their peak flow logs/diaries to their provider.~~ • ~~Hospital may wish to communicate with selected patients about a new smoking cessation program.~~ • Notification of patient surrogate of the results of tests (such as x-ray) or assessments (such as Fall Risk) • e-Mail notification of care plan conference schedules • Automated notification regarding annual flu shots	DC.1.1.3 DC.1.11.3 S.1.3.6 S.1.4.1 S.3.5.1 S.3.5.3 S.3.5.4 S.3.7.1 S.3.7.2 S.3.7.3 S.3.7.4 IN.1.5 IN.1.6 IN.1.7 IN.1.9 IN.2.2 IN.6	1. The system **SHALL** provide the ability to capture documentation of communications between providers and patients and/ or the patient representatives.	630	DC.3.2.3	1	N/C
						2. The system **SHALL** provide the ability to incorporate scanned documents.	631	DC.3.2.3	2	N/C
						3. The system **SHALL** provide the ability to document communication originating with the patient or patient representative (e.g. date, entity, details of communication).	632	DC.3.2.3	3	N/C
						4. The system **SHOULD** provide the ability to communicate between providers and patients or their representative using a secure internet connection.	633	DC.3.2.3	4	N/C
						5. The system **SHALL** provide the ability to manage documentation regarding family member or patient representative authorizations to receive patient related health information.	634	DC.3.2.3	5	N/C
						6. The system **SHOULD** alert providers to the presence of patient or patient representative originated communications.	635	DC.3.2.3	6	N/C
						7. The system ~~**SHOULD**~~ **MAY** provide the ability to alert patients or patient representative to provider absences (e.g., vacations) and recommend rerouting of the information or request.	636	DC.3.2.3	7	M
						~~8. The system **MAY** provide the ability to notify providers of events and new treatment options.~~	637	DC.3.2.3	8	D

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						9. The system **MAY** provide the ability to remind the patient or patient representative of events related to their care (e.g. upcoming appointments) as agreed upon by the patient and/or the patient representative.	638	DC.3.2.3	9	N/C
						10. The system **SHALL** conform to function IN.1.4 (Patient Access Management).	639	DC.3.2.3	10	N/C
						11. IF the system is used to enter, modify, or exchange data, THEN the system **SHALL** conform to IN.1.5 (Non-Repudiation) to guarantee that the sources and receivers of data cannot deny that they entered/modified/sent/ received the data.	640	DC.3.2.3	11	M
DC.3.2.4	**F**	**EF 2010**	Patient, Family and Care Giver Education	**Statement**: Facilitate access to educational or support resources pertinent to, and usable by, the patient or patient representative. **Description**: The provider or patient is presented with a library of educational materials. Material may be made available in the language or dialect understood by the patient or representative. Material should be at the level of the patient or representative's level of understanding and sensory capability. Special needs are documented. Material may be disseminated via a mode available to and acceptable by the patient (e.g., printed, electronically or otherwise). The review of material between the clinician and the patient, and the patient's	DC.2.1.4 DC 3.2.3 S.3.5.1 S.3.5.3 S.3.5.4 S.3.7.1 S.3.7.2 S.3.7.4 IN.1.4 IN.1.6 IN.1.7 IN.1.9 IN.2.2	1. The system **SHALL** provide the ability to access ~~to~~ a library of educational material for health concerns, conditions, and/or diagnosis.	641	DC.3.2.4	1	M
						2. The system **SHALL** provide the ability to communicate applicable educational materials to the patient and/or patient representative.	642	DC.3.2.4	2	N/C
						3. The system **MAY** provide ~~the ability to deliver multilingual~~ educational material in multiple languages.	643	DC.3.2.4	3	M
						4. The system **MAY** provide ~~the ability to deliver~~ patient educational materials using alternative modes to accommodate patient sensory capabilities.	644	DC.3.2.4	4	M
						5. ~~The system **MAY** provide the ability to access to external educational materials~~.	645	DC.3.2.4	5	D

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				understanding of the review, is documented when desired by the clinician. The patient or patient's representatives are able to obtain educational information independently without formal review with the clinician if desired.		6. The system **MAY** provide the ability to use rules-based support to identify the most pertinent educational material, based on the patient health status, condition and/or diagnosis.	646	DC.3.2.4	6	N/C
						7. The system **MAY** provide the ability to document who received the educational material provided (the patient or the patient representative).	647	DC.3.2.4	7	N/C
						8. The system **MAY** provide the ability to document that the educational material was reviewed with the patient and/or patient representative and their comprehension of the material.	648	DC.3.2.4	8	N/C
						9. The system **MAY** provide ~~the ability to identify age-appropriate and/or reading-ability appropriate educational materials for the patient and/or patient representative~~ educational materials written for various ages and/or reading ability.	649	DC.3.2.4	9	M
						10. The system **MAY** provide the ability for direct access to the educational material available, by patients and/or patient representatives.	650	DC.3.2.4	10	N/C
						11. IF the system provides access to personal health information in the context of accessing patient education materials, THEN the system **SHALL** conform to function IN.1.4 (Patient Access Management).	651	DC.3.2.4	11	M

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						12. IF the system is used to enter, modify, or exchange data, THEN the system **SHALL** conform to IN.1.5 (Non-Repudiation) to guarantee that the sources and receivers of data cannot deny that they entered/modified/sent/ received the data.	652	DC.3. 2.4	12	M
DC.3.2.5	**F**	**EF 2011**	Communication with Medical Devices	**Statement**: Support communication and presentation of data captured from medical devices. **Description**: Communication with medical devices is supported. ~~as appropriate to the care setting such as an office or a patient's home~~. Examples include: vital signs/pulse-oximeter, ~~anesthesia machines~~, home diagnostic devices for chronic disease management, laboratory machines, bar coded artifacts (medicine, immunizations, demographics, history, and identification), etc.	IN.1.1 IN.1.2 IN.1.3 IN.1.6 IN.1.7 IN.1.9 IN.4.1 IN.4.2 IN.4.3 IN.5.1 IN.5.2 IN.5.3 IN.7	1. The system **SHALL** provide the ability to collect accurate electronic data from medical devices according to ~~realm-specific applicable regulations and/or requirements~~ scope of practice, organizational policy or jurisdictional law.	653	DC.3. 2.5	1	M
						2. The system ~~**SHOULD**~~ **SHALL** provide the ability to present information collected from medical devices as part of the medical record ~~as appropriate~~.	654	DC.3. 2.5	2	M
						3. IF the system provides access to personal health information in the context of the patient viewing information generated by the medical device, THEN the system **SHOULD** conform to function IN.1.4 (Patient Access Management).	655	DC.3. 2.5	3	M

LONG-TERM CARE-NURSING HOMES EHR-SYSTEMS FUNCTIONAL PROFILE: RELEASE 1

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Main Report
- HTML: http://aspe.hhs.gov/daltcp/reports/2008/LNEHRSFP1.htm
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Direct Care Functions
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Supportive Functions
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Information Infrastructure Functions
- HTML: http://aspe.hhs.gov/daltcp/reports/2008/LNEHRSFP1-iif.htm
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APPENDIX: HIT Standards
- HTML: http://aspe.hhs.gov/daltcp/reports/2008/LNEHRSFP1-A.htm
- PDF: http://aspe.hhs.gov/daltcp/reports/2008/LNEHRSFP1-A.pdf