

NCPDP-HL7 Pharmacy/Pharmacist Provider Functional Profile Work Group

Pharmacy/Pharmacist Provider Functional Profile

Informative Level Ballot, Release 1 July 2010

Chapter Three: Direct Care Functions

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Chapter 3: Direct Care EHR-S Functions

Direct care EHR-S functions are the subset of EHR-S functions that enable delivery of healthcare and offer clinical decision support.

1 Example

For example, when a patient is identified to a pharmacist/pharmacy provider as needing medication therapy management (MTM), the Direct Care EHR-S will be used to obtain clinical medication-related data.

Function will enable the pharmacist/pharmacy provider to obtain and update medication related information for a comprehensive MTM review. Additionally, functions within the Direct Care EHR-S section will enable the provider to communicate medication related problems to the personal health record, care givers and other healthcare provider's EHR systems.

2 Actors

The principal users of these functions are expected to be authorized healthcare providers. The provider will receive appropriate medication related data, as well as support from the EHR-S to enable effective electronic communication among providers, and between providers and patients.

3 Functional Outline – Direct Care

Direct Care	DC.1	Care Management
	DC.2	Clinical Decision Support
	DC.3	Operations Management and Communication

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
DC.1	H	Care Management EN	<p>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.</p> <p>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).</p> <p>In the Direct Care functions there are</p>		1. The system SHALL conform to function IN.1.1 (Entity Authentication).	1
					2. The system SHALL conform to function IN.1.2 (Entity Authorization).	2
					3. The system SHALL conform to function IN.1.3 (Entity Access Control).	3
					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
					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
					6. IF the system exchanges data outside of a secure network, THEN the system SHALL conform to Function IN.1.7 (Secure Data Routing), to ensure that the exchange occurs only among authorized senders and receivers.	6
					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
					8. The system SHALL conform to function IN.1.9 (Patient Privacy and Confidentiality).	8
					9. The system SHALL conform to function IN.2.1 (Data Retention, Availability and Destruction).	9
					10. The system SHOULD conform to function IN.2.3 (Synchronization).	10
					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

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
			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).		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
					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
			Registry and directory services are not essential to a standalone electronic prescribing system. However, if provided, the criterion 14 would apply.		14. The system SHOULD-MAY conform to function IN.3 (Registry and Directory Services).	14
					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
					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
					17. The system SHOULD conform to function IN.4.3 (Terminology Mapping).	17
					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
					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
					20. The system SHOULD conform to function IN.5.3 (Standards-based Application Integration).	20

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
					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
					22. The system SHOULD SHALL conform to function IN.6 (Business Rules Management).	22
					23. The system SHOULD conform to function IN.7 (Workflow Management).	23
					24. The system SHALL conform to function S.2.2.1 (Health Record Output).	24
DC.1.1	H	Record Management EN	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.1.1.1	F	Identify and Maintain a Patient Record EN	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	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
					2. The IF the identity of a patient is unknown, THEN system SHALL provide the ability to create a record for the unknown patient according to scope of practice, organizational policy, or jurisdictional law. system SHALL provide the ability to create a record for a patient when the identity of the patient is unknown.	27
					3. The system SHALL provide the ability to store more than one identifier for each patient record.	28

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
			captured for the wrong patient, helps maintain health information for a single patient. In the 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.		<p>4. The system SHALL associate key identifier information (e.g., system ID, medical record number) with each patient record.</p> <p>5. The system SHALL provide the ability to uniquely identify a patient and tie the record to a single patient.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>10. The system SHOULD 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.</p> <p>11. IF related patients register with any identical data, THEN the system SHOULD provide the ability to propagate that data to all their records.</p> <p>12. The system SHALL conform to function IN.2.2 (Auditable Records).</p>	<p>29</p> <p>30</p> <p>31</p> <p>32</p> <p>33</p> <p>34</p> <p>35</p> <p>36</p> <p>37</p>
					<p>13. <u>The system SHOULD provide the ability to identify a patient by an alias and tie the record to a single patient.</u></p>	<p><u>NEW 38</u></p>
DC.1.1.2	F	Manage Patient Demographics	Statement: Capture and maintain demographic information. Where	S.1.4.1	<p>1. The system SHALL capture demographic information as part of the patient record.</p>	<p><u>3839</u></p>

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
		EN	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.2.2.2 IN.2.1 IN.2.2 IN.2.4	2. The system SHALL store and retrieve demographic information as discrete data. 3. The system SHALL provide the ability to retrieve demographic data as part of the patient record. 4. The system SHALL provide the ability to update demographic data. 5. The system SHOULD provide the ability to report demographic data. 6. The system SHOULD store historical values of demographic data over time. 7. The system SHALL present a set of patient identifying information at each interaction with the patient record. 8. The system SHOULD conform to function IN.1.4 (Patient Access Management). 9. The system SHALL conform to function IN.2.2 (Auditable Records). 10. The system MAY store the demographic information (and other meaningful individual identifiers) separately from clinical data for identity protection purposes.	3940 410 421 432 443 454 465 476 NEW 48
					11. The system SHOULD provide the ability to capture and maintain multiple addresses.	NEW 49
					12. The system SHOULD provide the ability to capture and maintain multiple phone numbers.	New 50
DC.1.1.3	H	Data and Documentation from External Sources EN	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). 2. The system SHALL conform to function IN.2.2 (Auditable Records).	5147 5248
DC.1.1.3.1	F	Capture Data and Documentation from	Statement: Incorporate clinical data and documentation from external	IN.1.5	1. The system SHALL provide the ability to capture external data and documentation.	5349

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
		External Clinical Sources EN	sources. Description: Mechanisms for incorporating external clinical data and documentation (including identification of source) such as image documents and other clinically relevant data are available. Data incorporated through these mechanisms is presented alongside locally captured documentation and notes wherever appropriate.	IN.1.6 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. 3. IF lab results are received through an electronic interface, THEN the system SHALL display them upon request. 4. The system SHOULD provide the ability to receive, store and display scanned documents as images. 5. The system MAY-SHOULD provide the ability to store imaged documents or reference the imaged documents via links to imaging systems. 6. The system SHOULD provide the ability to receive, store and present text-based externally-sourced documents and reports. 7. The system SHOULD-MAY provide the ability to receive, store and display clinical result images (such as radiologic images) received from an external source. 8. The system SHOULD-MAY 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. 9. The system SHOULD-SHALL provide the ability to receive, store and present medication details from an external source. 10. The system SHOULD-MAY provide the ability to receive, store and present structured text-based reports received from an external source. 11. The system SHOULD provide the ability to receive, store and present standards-based structured, codified data received from an external source.	5450 5554 5652 573 584 595 6056 6157 6258 6359
					12. The system SHOULD have the ability to receive medication histories and have the ability to integrate them into the Medication List	NEW 64
DC.1.1.3.2	F	Capture Patient-Originated Data Optional	Statement: Capture and explicitly label patient-originated data, link the data source with the data, and support provider authentication for inclusion in	IN.1.4 IN.2.5.1 IN.2.5.2	1. The system SHALL capture and explicitly label patient-originated data.	650

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
			<p>patient health record.</p> <p>Description: It is critically important to be able to distinguish patient-originated data that is either provided or entered by a 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.</p> <p>Data about the patient may be appropriately provided by:</p> <ol style="list-style-type: none"> 1. the patient 2. a surrogate (parent, spouse, guardian) or 3. an informant (teacher, lawyer, case worker). <p>An electronic health record may provide the ability for direct data entry by any of these.</p> <p>Patient-originated data may also be captured by devices and transmitted for inclusion into the electronic health record.</p> <p>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.</p>		<p>2. IF the system provides the ability for direct entry by the patient, THEN the system SHALL explicitly label the data as patient entered.</p> <p>3. The system SHALL capture and label the source of clinical data provided on behalf of the patient.</p> <p>4. The system SHALL present patient-originated data for use by care providers.</p> <p>5. The system SHALL provide the ability for a provider to verify the accuracy of patient-originated data for inclusion in the patient record.</p> <p>6. The system SHOULD provide the ability to view or comment, but not alter, patient-originated data.</p>	<p>664</p> <p>672</p> <p>683</p> <p>694</p> <p>7065</p>
					<p>7. The system SHALL provide the ability to capture patient originated data including, but not limited to, demographics, past medical history, medications, and allergies.</p>	<p>NEW 71</p>

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
DC.1.1.3.3	F	Capture Patient Health Data Derived from Administrative and Financial Data and Documentation Optional	<p>Statement: Capture and explicitly label patient health data derived from administrative or financial data; and link the data source with that data.</p> <p>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 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:</p> <ol style="list-style-type: none"> 1. the patient 2. a provider 3. a payer, or 4. entities that transmit or process administrative or financial data. <p>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.</p>	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.	6672
					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.	7367
					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.	7468
					4. The system SHOULD provide the ability to view or comment on patient health information derived from administrative or financial data.	7569
					5. The system SHOULD provide the ability to request correction of the administrative or financial data.	7670
DC.1.1.4	F	Produce a Summary Record of Care EN	<p>Statement: Present a summarized review of a patient's episodic and/or comprehensive EHR, subject to jurisdictional laws and organizational policies related to privacy and</p>	S.2.2.1 IN.1.9 IN.2.4	1. The system SHALL present summarized views and reports of the patient's comprehensive EHR.	774
					2. The system SHOULD include at least the following in the summary: problem list, medication list, allergy and adverse reaction list.	782

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
			confidentiality. Description: Create summary views and reports at the conclusion of an episode of care. Create service reports at the completion of an episode of care such as, but not limited to, discharge summaries and public health reports, without additional input from clinicians.	IN.2.5.1 IN.2.5.2	3. The system SHOULD conform to function S.3.3.6 (Health Service Reports at the Conclusion of an Episode of Care). 4. The system SHOULD conform to function IN.1.4 (Patient Access Management). 5. The system SHALL conform to function IN.2.2 (Auditable Records).	793 8074 8175
DC.1.1.5	F	Present Ad Hoc Views of the Health Record EN	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. 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, depending on need. Jurisdictional laws and organizational policies that prohibit certain users from accessing certain patient information must be supported.	S.1.8 S.2.2.3 S.3.1.1 IN.1.3 IN.1.6 IN.1.7 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	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. 2. The system SHOULD 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. 3. The system SHOULD provide the ability to access summarized information through customized views based on prioritization of chronology, problem, or other pertinent clinical parameters. 4. The system SHOULD conform to function IN.1.4 (Patient Access Management). 5. The system SHALL conform to function IN.2.2 (Auditable Records).	8276 8377 8478 8579 8680
DC.1.2	F	Manage Patient History EN	Statement: Capture and maintain medical, procedural/surgical, social and family history including the capture of pertinent positive and negative histories,	S.2.2.1 S.3.5	1. The system SHALL provide the ability to capture, update and present current patient history including pertinent positive and negative elements, and information on clinicians involved.	8784

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
			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, clinicians involved in procedures or in past consultations, 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 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.	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	2. The system SHOULD provide the ability to capture and present previous external patient histories. 3. The system MAY provide the ability to capture the relationship between patient and others. 4. The system SHALL capture the complaint, presenting problem or other reason(s) for the visit or encounter. 5. The system SHOULD capture the reason for visit/encounter from the patient's perspective. 6. The system SHOULD conform to function IN.1.4 (Patient Access Management). 7. The system SHALL conform to function IN.2.2 (Auditable Records).	8882 893 9084 9185 9286 9387
DC.1.3	H	Preferences, Directives, Consents and Authorizations EN			1. The system SHOULD conform to function IN.1.4 (Patient Access Management). 2. The system SHALL conform to function IN.2.2 (Auditable Records).	9488 9589
DC.1.3.1	F	Manage Patient and Family Preferences EN	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	DC.1.3.2 DC.1.3.3 DC.2.1.4 S.3.7.1 IN.2.5.1	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 culture. 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 culture.	9690 9791

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
			provider at the point of care. -NOTE: This function is focused on the capture and maintenance of facts on patient/family preferences. For issues related to death and dying see DC.1.3.2	IN.2.5.2 IN.6	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.	982
DC.1.3.2	F	Manage Patient Advance Directives EN	Statement: Capture and maintain patient advance directives. 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.	DC.1.3.1 DC1.3.3 S.3.5.1 S.3.5.3 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	1. The system SHALL provide the ability to indicate that advance directives exist for the patient.	993
					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".	10094
					3. The system SHOULD provide the ability to capture, present, maintain and make available for clinical decisions patient advance directives documents and "Do Not Resuscitate" orders.	95101
					4. The system SHOULD 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.	10296
					5. The system SHOULD provide the ability to indicate when advanced directives were last reviewed.	10397
					6. The system SHOULD provide the ability to indicate the name and relationship of the party completing the advance directive for the patient.	10498
					7. The system SHALL time and date stamp advance directives.	10599
					8. The system SHOULD provide the ability to document the location and or source of any legal documentation regarding advance directives.	1060
					9. The system SHOULD conform to function DC.2.1.4 (Support for Patient and Family Preferences).	1074
DC.1.3.3	F	Manage Consents and Authorizations	Statement: Create, maintain, and verify patient decisions such as informed consent for treatment and	DC.1.1.3 DC.1.3.1	1. The system SHALL provide the ability to indicate that a patient has completed applicable consents and authorizations.	1082

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
		EN	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. 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).	DC.1.3.2 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	2. The system SHALL provide the ability to indicate that a patient has withdrawn applicable consents and authorizations. 3. The system SHOULD conform to function DC.1.1.3.1 (Capture Data and Documentation from External Clinical Sources) and capture scanned paper consent and authorization documents. 4. The system SHOULD provide the ability to view and complete consent and authorization forms on-line. 5. The system MAY provide the ability to generate printable consent and authorization forms. 6. The system MAY display the authorizations associated with a specific clinical activity, such as treatment or surgery, along with that event in the patient's electronic chart. 7. The system MAY provide the ability to display consents and authorizations chronologically. 8. The system SHOULD provide the ability to document an assent for patients legally unable to consent. 9. The system SHALL provide the ability to document the source of each consent, such as the patient or the patient's personal representative if the patient is legally unable to provide it. 10. The system SHOULD provide the ability to document the patient's personal representative's level of authority to make decisions on behalf of the patient.	1093 1104 1105 11206 11307 11408 11509 14016 1174
DC.1.4	H	Summary Lists EN		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). 2. The system SHALL conform to function IN.2.2 (Auditable Records).	1182 1193

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DC.1.4.1	F	Manage Allergy, Intolerance and Adverse Reaction List EN	<p>Statement: Create and maintain patient-specific allergy, intolerance and adverse reaction lists.</p> <p>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.</p>	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.	1154
					2. The system SHOULD provide the ability to capture the reason for entry of the allergy, intolerance or adverse reaction.	1165
					3. The system SHALL provide the ability to capture the reaction type.	1176
					4. The system SHOULD provide the ability to capture the severity of a reaction.	1187
					5. The system SHALL provide the ability to capture a report of No Known Allergies (NKA) for the patient.	1198
					6. The system SHOULD provide the ability to capture a report of No Known Drug Allergies (NKDA) for the patient.	12049
					7. The system SHOULD provide the ability to capture the source of allergy, intolerance, and adverse reaction information.	1210
					8. The system SHALL provide the ability to deactivate an item on the list.	1224
					9. The system SHALL provide the ability to capture the reason for deactivation of an item on the list.	1232
					10. The system MAY present allergies, intolerances and adverse reactions that have been deactivated.	1243
					11. The system MAY provide the ability to display user defined sort order of list.	1254
					12. The system SHOULD provide the ability to indicate that the list of medications and other agents has been reviewed.	1265
					13. The system SHALL provide the ability to capture and display the date on which allergy information was entered.	1276
					14. The system SHOULD provide the ability to capture and display the approximate date of the allergy occurrence.	1287
					15. The system SHOULD provide the ability to capture, display and report codified allergy information.	NEW 129

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					16. The system MAY provide the ability to capture, display and report allergy information as free text.	NEW 130
DC.1.4.2	F	Manage Medication List EN	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 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.	S.2.2.1 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.5.4 IN.6	1. The system SHALL provide the ability to capture patient-specific medication lists.	13128
					2. The system SHALL display and report patient-specific medication lists.	13229
					3. The system SHALL provide the ability to capture the details of the medication when known such as ordering date, medication identifier (RxNorm/NDC) , dose, route, and SIG (description of the prescription, such as the quantity) when known.	1339
					4. The system SHOULD provide the ability to capture other dates associated with medications such as start and end dates.	1344
					5. The system SHALL provide the ability to capture medications not reported on existing medication lists or medication histories.	1352
					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.	1363
					7. The system SHALL present the current medication lists associated with a patient.	1374
					8. The system SHOULD present the medication history associated with a patient.	1385
					9. The system SHALL present the details of the medication, when known, such as prescriber, and medication ordering dates when known .	1396
					10. The system SHALL provide the ability to mark a medication as erroneously captured and excluded from the presentation of current medications.	14037
					11. The system SHALL provide the ability to print a current medication list for patient use.	14138
					12. The system MAY provide the ability to capture information regarding the filling of prescriptions (dispensation of medications by pharmacies or other providers).	14239

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					13. The system SHALL maintain coded list of medications including a unique identifier for each medication.	NEW 143
					14. The system SHOULD maintain a coded list of medications including an RX Norm identifier for each medication.	NEW 144
					15. The system SHALL provide the ability to query (for example a plan, payer or pharmacy) for a medication history.	NEW 145
DC.1.4.3	F	Manage Problem List EN	Statement: Create and maintain patient- specific problem lists. Description: A problem list may include, but is not limited to: Chronic conditions, diagnoses, or symptoms, functional limitations, visit or stay-specific conditions, diagnoses, or symptoms. 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.1.7.1 DC.1.7.2.1 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.	1460
					2. The system SHALL capture, display and report a history of all problems associated with a patient.	1474
					3. The system SHALL provide the ability to capture onset date of problem.	1482
					4. The system SHOULD provide the ability to capture the chronicity (chronic, acute/self-limiting, etc.) of a problem.	1493
					5. The system SHALL provide the ability to capture the source, date and time of all updates to the problem list.	15044
					6. The system SHALL provide the ability to deactivate a problem.	15145
					7. The system MAY provide the ability to re-activate a previously deactivated problem.	15246
					8. The system SHOULD provide the ability to display inactive and/or resolved problems.	15347
					9. The system SHOULD provide the ability to manually order/sort the problem list.	15448
					10. The system MAY provide the ability to associate encounters, orders, medications, notes with one or more problems.	15549
DC.1.4.4	F	Manage Immunization List	Statement: Create and maintain patient-specific immunization lists. Description: Immunization lists are	DC.1.8.2 DC.1.8.5	1. The system SHALL capture, display and report all immunizations associated with a patient	15650

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		EN	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.		2. The system SHALL record as discrete data elements data associated with any immunization given including date, type, lot number and manufacturer	15754
					3. The system SHOULD prepare a report of a patient 's immunization history upon request for appropriate authorities such as schools or day-care centers	1582
DC.1.4.5		Manage Medication Associated Diagnosis List EN From eRx DC.1.4.3	Statement: Create and maintain medication — specific diagnosis lists for a patient. Description: Diagnosis lists are managed over time to serve as basis for the prescribing of specific medications.	DC.1.7.1.1 DC.1.7.4.1 S.2.2.1 IN.2.4 IN.2.5.1 IN.2.5.2 IN.4.1	1. The system SHALL provide the ability to create, display and report diagnoses associated with medications to be prescribed.	NEW 159
					2. The system SHOULD capture the source, date and time of all updates to the diagnosis list.	NEW 160
					3. The system SHOULD provide the ability to change the medication specific diagnosis relationship displayed and reported.	NEW 161
					4. The system SHALL provide the ability to capture and display the diagnoses associated with medications previously prescribed for the specific patient.	NEW 162
					5. The system MAY provide the ability to manually order/sort the diagnosis list.	NEW 163
DC.1.5	F	Manage Assessments EN	Statement: Create and maintain assessments. Description: During an encounter with a patient, the provider will conduct an	DC.1.5 DC.1.6.2	1. The system SHALL provide the ability to create assessments.	16453
					2. The system SHOULD provide the ability to use standardized assessments where they exist.	16554

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			assessment that is germane to the age, gender, developmental or functional state, medications , medical and behavioral condition of the patient, such as growth charts, developmental profiles, and disease specific assessments. Wherever 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.	DC.1.8.5 DC.1.10.1 DC.2.1.1 DC.2.1.2 DC.2.2.1 S.2.2.1 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 provide the ability to document using standard assessments germane to the age, gender, developmental state, and health condition as appropriate to the EHR user's scope of practice. 4. The system SHOULD provide the ability to capture data relevant to standard assessment. 5. The system SHOULD provide the ability to capture additional data to augment the standard assessments relative to variances in medical conditions. 6. The system SHOULD provide the ability to link data from a standard assessment to a problem list. 7. The system SHOULD provide the ability to link data from a standard assessment to an individual care plan. 8. The system MAY provide the ability to link data from external sources, laboratory results, and radiographic results to the standard assessment. 9. The system SHOULD provide the ability to compare documented data against standardized curves and display trends. 10. The system SHOULD conform to function IN.1.4 (Patient Access Management). 11. The system SHALL conform to function IN.2.2 (Auditable Records). 12. The system SHALL provide the ability to link data from a standard assessment to a medication list.	1 66 55 1 67 56 1 68 57 1 69 58 1 70 59 1 71 60 1 72 61 1 73 62 1 74 63 NEW 175
DC.1.6	H	Care Plans, Treatment Plans, Guidelines, and Protocols EN				1 75 64
DC.1.6.1	F	Present Guidelines and Protocols for Planning Care EN	Statement: Present organizational guidelines for patient care as appropriate to support planning of care, including order entry and clinical documentation.	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. 2. The system SHOULD provide the ability to search for a guideline or protocol based on appropriate criteria (such as problem or medication).	1 76 65 1 77 66

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			Description: Guidelines, and protocols presented for planning care may be site specific, community or industry-wide standards.	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 guidelines and protocols for historical or legal purposes. 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). 5. The system SHALL conform to function DC.2.2.1.2 (Support for Context-Sensitive Care Plans, Guidelines, Protocols). 6. The system SHOULD conform to function IN.2.2 (Auditable Records).	17867 17968 18069 18170
DC.1.6.2	F	Manage Patient-Specific Care and Treatment Plans EN	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, including alerts. 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.2.1.4 DC.2.2.1.1 DC.2.2.1.2 DC.2.3.1.2 DC.2.5.1 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. 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. 3. The system SHALL provide the ability to use previously developed care plans as a basis for the creation of new plans of care and treatment. 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. 5. The system SHOULD provide the ability to coordinate order sets with care plans. 6. The system SHOULD provide the ability to derive order sets from care plans. 7. The system SHOULD provide the ability to derive care plans from order sets. 8. The system SHALL provide the ability to transfer plans of care and treatment to other care providers.	18274 18372 18473 18574 18675 18776 18877 18978

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					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.	19079
					10. The system SHOULD conform to function DC.3.1.2 (Clinical Task Linking) and incorporate care plan items in the tasks linked.	19180
					11. The system SHOULD conform to function DC.3.1.3 (Clinical Task Tracking) and incorporate care plan items in the tasks tracked.	19284
					12. The system SHALL conform to function IN.2.2 (Auditable Records).	19382
					13. The system SHOULD provide information from DC.2.3.1.2 (Support for Patient Specific Dosing and Warnings) to provide effective treatment and any related warnings on interactions and warnings.	194
					14. The system MAY provide the ability to use information from DC.2.1.4 (Support for Patient and Family Preferences) to improve the effectiveness of care and treatment plans.	195
DC.1.7	H	Orders and Referrals Management EN			1. The system SHALL conform to function IN.2.2 (Auditable Records).	18396
DC.1.7.1	F	Manage Medication Orders EN	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	DC.1.4.3 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	1. The system SHALL provide the ability to create prescription or other medication orders with the details adequate for correct filling and administration captured as discrete data. 2. The system SHALL capture user and date stamp for all prescription related events. 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). 4. The system SHALL provide a list of medications to search, including both generic and brand name. 5. The system SHALL provide the ability to maintain a discrete list of orderable medications.	19784 19885 19986 200487 201488

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			<p>clinicians, or the ordering clinician is facilitated in creating such instructions. The system may allow for the creation of common content for prescription details. 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 clinician to decide whether to continue with the order. Formulary-compliant alternatives to the medication being ordered may also be presented.</p> <p>In some pharmacy practice settings the sharing of formulary and benefit information from the PBM with the pharmacy is not possible.</p>	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	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. 7. The system MAY make common content available for prescription details to be selected by the ordering clinician. 8. The system MAY provide the ability for the ordering clinician to create prescription details as needed. 9. The system MAY make available common patient medication instruction content to be selected by the ordering clinician. 10. The system MAY provide the ability to include prescriptions in order sets. 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. 12. The system MAY provide the ability to select drugs by therapeutic class and/or indication. 13. The system MAY 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. 14. The system MAY provide the ability to re-prescribe medication by allowing a prior prescription to be reordered without re-entering previous data (e.g. administration schedule, quantity). 15. The system SHOULD SHALL provide the ability to re-prescribe a medication from a prior prescription using the same dosage but allow for editing of details adequate for correct filling and administration of medication (e.g. dose, frequency, body weight). 16. The system SHOULD SHALL 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 medications are ordered.	202189 203190 204191 205192 206193 207194 208195 209196 210197 211198 212199

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					17. The system SHOULD SHALL 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.	21300
					18. The system SHOULD SHALL provide the ability to create prescriptions in which the weight-specific dose is suggested.	21401
					19. The system SHOULD conform to function DC.2.3.1.3 (Support for Medication Recommendations).	21502
DC.1.7.2	H	Non-Medication Orders and Referrals Management EN				21603
DC.1.7.2.1	F	Manage Non-Medication Patient Care Orders EN	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, to ambulate a patient, for medical supplies, durable medical equipment, home IV, 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.1.4.3 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 2. The system SHALL provide the ability to capture adequate order detail for correct order fulfillment 3. The system SHALL track the status of the ordered action or item 4. The system SHOULD provide the ability to capture patient instructions necessary for correct order fulfillment 5. The system SHOULD provide the ability to present patient instructions necessary for correct order fulfillment 6. The system SHOULD provide the ability to communicate the order to the correct recipient(s) for order fulfillment 7. The system SHALL conform to DC.2.4.2 (Support for Non-Medication Ordering)	21704 21805 21906 22007 22108 22209 22340
DC.1.7.2.2	F	Manage Orders for Diagnostic Tests EN	Statement: Enable the origination, documentation, and tracking of orders for diagnostic tests. Description: Orders for diagnostic tests (e.g. diagnostic radiology, laboratory)	DC.2.4.5.2 S.2.2.1 S.3.7.1	1. The system SHALL provide the ability to capture orders for diagnostic tests. 2. The system SHALL provide the ability to capture adequate order detail for correct diagnostic test fulfillment.	22444 24542

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			are captured and tracked including new, 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). Some systems may contain instructions, but in some settings, instructions may be provided from external sources (e.g., handouts).	IN.1.6 IN.1.7 IN.2.5.1 IN.2.5.2 IN.6	3. The system SHALL provide the ability to track the status of diagnostic test(s). 4. The system SHOULD provide the ability to capture and present patient instructions relevant to the diagnostic test ordered. 5. The system SHALL communicate orders to the service provider of the diagnostic test. 6. The system SHOULD communicate supporting detailed documentation to the correct service provider of the diagnostic test. 7. The system SHALL conform to DC.2.4.2 (Support for Non-Medication Ordering).	22643 22744 22845 22946 23047
DC.1.7.2.3	F	Manage Orders for Blood Products and Other Biologics Optional	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. 2. The system SHALL provide the ability to capture use of such products in the provision of care. 3. The system SHOULD conform to function S.1.1 (Registry Notification).	23148 23249 23320
DC.1.7.2.4	F	Manage Referrals EN	Statement: Enable the origination, documentation and tracking of referrals between care providers or healthcare organizations, including clinical and administrative details of the referral, and consents and authorizations for disclosures as required. Description: Documentation and tracking of a referral from one care	DC.1.9.3 DC.2.4.4.1 DC.2.4.4.2 S.1.3.1a S.1.3.5 S.3.3.2	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. 2. The system SHALL provide the ability to capture clinical details as necessary for the referral. 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.	23424 23522 23623

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			provider to another is supported, whether the referred to or referring providers are internal or external to the healthcare organization. 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.	S.3.3.3 IN.1.6 IN.1.7 IN.2.5.1 IN.2.5.2	4. The system SHALL present captured referral information. 5. The system SHOULD provide the ability to capture completion of a referral appointment. 6. The system SHOULD provide diagnosis based clinical guidelines for making a referral. 7. The system MAY provide order sets for referral preparation. 8. The system SHALL provide the ability to document transfer of care according to organizational policy, scope of practice, and jurisdictional law. 9. The system MAY provide guidelines to the provider about the appropriateness of a referral for a particular patient.	23724 23825 22926 24027 228241 NEW 242
DC.1.7.3	F	Manage Order Sets EN	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 presented based on patient data, medication or other contexts.	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). 2. The system SHALL provide the ability to order at the patient level from presented order sets. 3. The system SHALL provide the ability to record each component of an order set that is ordered. 4. The system SHALL conform to function DC.2.4.1 (Support for Order Sets). 5. The system MAY provide the ability for a provider to choose from among the order sets pertinent to a certain disease, medication or other criteria.	24329 24430 24534 24632 24733
					6. The system MAY capture the order sets used by the provider during an encounter for analysis of order set use. The system MAY capture the order sets used by the provider during an encounter for analysis of order set use.	NEW 248
DC.1.8	H	Documentation of Care, Measurements and Results EN			1. The system SHALL conform to function IN.2.2 (Auditable Records)	24934
DC.1.8.1	F	Manage Medication Administration	Statement: Present providers with the list of medications that are to be administered to a patient, necessary	DC.1.1.1 DC.2.3.1.1	1. The system SHALL present the list of medications to be administered.	25035

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
		Optional	administration information, and capture administration details. Description: In a setting in which medication orders are to be administered by a provider (e.g. pharmacist) 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. If the pharmacist administers drugs, then the system must provide the functionality.	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	2. The system SHALL display the timing, route of administration, and dose of all medications on the list. 3. The system SHOULD display instructions for administration of all medications on the list. 4. The system MAY notify the clinician when specific doses are due. 5. The system MAY 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 medications are about to be given/administered . 6. The system MAY 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/administered . 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. 8. The system SHALL securely relate interventions to be administered to the unique identity of the patient.	25136 25237 25338 25439 25540 25641 25742
DC.1.8.2	F	Manage Immunization Administration EN	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.	DC.1.3.2 DC.1.4.4 S.1.1 S.2.2.2 S.3.7.1 IN.1.6	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. 2. The system SHOULD provide the ability to recommend required immunizations based on patient risk factors. 3. The system SHALL perform checking for potential adverse or allergic reactions for all immunizations when they are about to be given.	25843 25944 26045

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
			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.	IN.1.7	4. The system SHALL provide the ability to capture immunization administration details, including date, type, lot number, expiration date , route of administration site of administration and manufacturer.	26146
				IN.2.4		
				IN.2.5.1		
				IN.2.5.2	5. The system SHOULD SHALL provide the ability to capture other clinical data pertinent to the immunization administration (e.g. vital signs).	26247
				IN.3.1		
				IN.3.2	6. The system SHALL record as discrete data elements data associated with any immunization.	26348
				IN.4.1	7. The system SHOULD provide the ability to associate standard codes with discrete data elements associated with an immunization.	26449
				IN.4.2		
				IN.4.3	8. The system SHALL provide the ability to update the immunization schedule.	26550
				IN.5.1	9-8.	
				IN.5.2	40-9. 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.	26654
				IN.6	44-10. The system SHALL conform to function DC.1.4.1 (Manage Allergy, Intolerance and Adverse Reaction Lists).	26752
					42-11. The system SHOULD transmit required immunization information to a public health immunization registry.	26853
					43-12. The system SHOULD receive immunization histories from a public health immunization registry.	26954
					13. The system SHALL display the timing, route of administration, and dose of all immunizations on the list.	NEW 270
					14. The system SHALL provide the ability to capture immunization administration details – including timestamps, observations, complications, and reason if medication was not given – in accordance with organizational policy, scope of practice, and jurisdictional law.	NEW 271

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DC.1.8.3	F	Manage Results EN	<p>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.</p> <p>Description: Results of tests are presented in an easily accessible 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.</p>	DC.2.4.3 S.2.2.1 S.3.7.1 IN.1.6 IN.1.7 IN.2.4 IN.2.5.1 IN.2.5.2 IN.6	1. The system SHALL provide the ability to present numerical and non-numerical current and historical test results to the appropriate provider.	27255
					2. The system SHALL provide the ability to filter results for a unique patient.	27356
					3. The system SHALL provide the ability to filter results by factors that supports results management, such as type of test and date range.	27457
					4. The system SHOULD indicate normal and abnormal results depending on the data source.	27558
					5. The system SHOULD provide the ability to filter lab results by range, e.g. critical, abnormal or normal.	27659
					6. The system SHOULD display numerical results in flow sheets, graphical form, and allow comparison of results.	27760
					7. The system SHALL provide the ability to group tests done on the same day.	27864
					8. The system SHOULD notify relevant providers (ordering, copy to) that new results have been received.	27962
					9. The system SHOULD provide the ability for the user, to whom a result is presented, to acknowledge the result.	28063
					10. The system SHOULD provide the ability to route results to other appropriate care providers, such as nursing home, consulting physicians, etc.	28164
					11. The system MAY route results to patients by methods such as phone, fax, electronically or letter.	28265
					12. The system SHOULD provide the ability for providers to pass on the responsibility to perform follow up actions to other providers.	28366
					13. The system MAY provide the ability for an authorized user to group results into clinically logical sections.	28467
					14. The system SHOULD trigger decision support algorithms from the results.	28568
					15. IF the system contains the electronic order, THEN the results SHALL be linked to a specific order.	28669
					16. The system MAY provide the ability for providers to annotate a result.	28770
					17. The system MAY display a link to an image associated with results.	28874

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					18. The system SHOULD provide the ability to link results to a specific medical condition, medication or therapeutic class of medication.	NEW 289
DC.1.8.4	F	Manage Patient Clinical Measurements EN	Statement: Capture and manage patient clinical measures, such as vital signs, as discrete patient data. Description: Within the context of an episode of care, 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 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.	29072
					2. IF required by the scope of practice, THEN the system SHALL capture psychiatric symptoms and daily functioning as structured or unstructured data.	29173
					3. The system SHOULD capture other clinical measures such as peak expiratory flow rate, size of lesions, oxygen saturation, height, weight, and body mass index as discrete elements of structured or unstructured data.	29274
					4. The system SHOULD compute and display percentile values when data with normative distributions are entered.	29375
					5. The system MAY provide normal ranges for data based on age and other parameters such as height, weight, ethnic background, gestational age.	29476
DC.1.8.5	F	Manage Clinical Documents and Notes EN	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. To facilitate the management and documentation on how providers are responding to incoming data on orders and results, there may also be some free text or formal record on the	IN.2.2 IN.2.5.1 IN.2.5.2 DC.1.5	1. The system SHALL provide the ability to capture clinical documentation (henceforth "documentation") including original, update by amendment in order to correct, and addenda.	29577
					2. The system SHALL provide the ability to capture free text documentation.	29678
					3. The system MAY present documentation templates (structured or free text) to facilitate creating documentation.	29779
					4. The system SHALL provide the ability to view other documentation within the patient's logical record while creating documentation.	29880
					5. The system SHOULD provide the ability to associate documentation for a specific patient with a given event, such as an office visit, phone communication, e-mail consult, lab result, etc.	29984
					6. The system SHOULD provide the ability to associate documentation with problems and/or diagnoses.	300282

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			providers' responsibility and/or standard choices for disposition, such as: Reviewed and Filed, Recall Patient, or Future Follow Up. The system may also provide support for documenting the clinician's differential diagnosis process.		7. The system SHALL provide the ability to update documentation prior to finalizing it.	301283
					8. The system SHALL provide the ability to finalize a document or note.	302284
					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)).	303285
					10. The system SHALL present captured documentation.	304286
					11. The system MAY provide the ability to filter, search or sort notes.	305287
					12. The system SHOULD provide documentation templates for data exchange.	306288
					13. The system MAY provide the ability for providers to record their acceptance of responsibility to perform follow up actions	288306a
					14. The system MAY provide the ability for providers to select and document standard choices for disposition of their review process.	288306b
					15. The system MAY provide the ability to support, capture and display the clinician's differential diagnosis and the list of diagnoses that the clinician has considered in the evaluation of the patient	288e306c
DC.1.8.6	F	Manage Documentation of Clinician Response to Decision Support Prompts EN	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. The system SHALL provide the ability to capture clinical decision support prompts and user decisions to accept or override those prompts.	307289
					2. The system SHALL provide the ability to record the reason for variation from the decision support prompt.	308290
					3. The system SHOULD provide the ability to display recorded variances upon request by authorized users of the EHR.	309291
					4. The system SHALL provide the ability for the pharmacist to record interventions on medication orders.	NEW 310
DC.1.9	F	Generate and Record Patient-Specific Instructions	Statement: Generate and record patient-specific instructions related to pre- and post-procedural and post-	DC.2.2.4 DC.2.7.2	1. The system SHALL provide the ability to generate instructions pertinent to the patient for standardized procedures.	311292

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
		EN	discharge requirements as applies to medication-related services . Description: When a patient is scheduled for a test, procedure, or discharge, specific instructions about medication , immunization , diet, clothing, transportation assistance, convalescence, follow-up with physician, etc., may be generated and recorded, including the timing relative to the scheduled standalone electronic prescribing event.	DC.3.2.3 DC.3.2.4 S.3.7.2 S.3.7.3 IN.1.8 IN.2.2 IN.6	2. The system SHALL provide the ability to generate instructions pertinent to the patient based on clinical judgment. 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. 4. The system SHALL provide the ability to record that instructions were given to the patient. 5. The system SHALL provide the ability to record the actual instructions given to the patient or reference the document(s) containing those instructions. 6. The system SHALL conform to function IN.2.2 (Auditable Records).	312293 313294 314295 315296 316297
DC.2	H	Clinical Decision Support EN			1. The system SHALL conform to function IN.1.1 (Entity Authentication). 2. The system SHALL conform to function IN.1.2 (Entity Authorization). 3. The system SHALL conform to function IN.1.3 (Entity Access Control). 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. 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. 6. IF the system exchanges outside of a secure network, THEN the system SHALL conform to function IN.1.7 (Secure Data Routing), to ensure that the exchange occurs only among authorized senders and receivers. 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. 8. The system SHALL conform to function IN.2.1 (Data Retention, Availability and Destruction).	317298 318299 31900 32004 32102 32203 32304 32405

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					9. The system SHOULD conform to function IN.2.3 (Synchronization).	32506
					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.	32607
					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.	32708
					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.	32809
					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.	329*40
					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.	33044
					15. The system SHOULD conform to function IN.4.3 (Terminology Mapping).	33142
					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.	33243

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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.	33314
					18. The system SHOULD conform to function IN.5.3 (Standards-based Application Integration).	33416
					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.	33516
					20. The system SHOULD conform to function IN.6 (Business Rules Management).	33617
					21. The system SHOULD conform to function IN.7 (Workflow Management).	33718
DC.2.1	H	Manage Health Information to Provide Decision Support EN			1. The system SHOULD conform to function IN.1.4 (Patient Access Management).	33819
					2. The system SHALL conform to function IN.1.9 (Patient Privacy and Confidentiality).	33920
					3. The system SHALL conform to function IN.2.2 (Auditable Records).	34021
					4. The system SHOULD conform to function IN.3 (Registry and Directory Services).	34122
DC.2.1.1	F	Support for Standard Assessments EN	Statement: Offer prompts to support the adherence to care plans, guidelines, and protocols at the point of information capture. 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 2 (Adult Onset) Diabetes	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 the standard assessment in the patient record.	34223
					2. The system SHALL provide the ability to access to health standards and practices appropriate to the EHR user's scope of practice.	34324
					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.	34425
					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.	34526

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
			diabetic review, fall and 70+, and rectal bleeding. Also, support for standard assessment may include the ability to record and store the value for the answers to specific questions in standardized assessment tools or questionnaires.		5. The system SHOULD provide prompts based on practice standards to recommend additional assessment functions.	34627
					6. The system SHOULD conform to function DC.1.4.3 (Manage Problem List) and medication related lists in DC.1.4 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.	34728
					7. The system SHOULD provide the ability to create standard assessments that correspond to the problem and medication lists .	34829
					8. The system SHOULD conform to function DC 2.1.2 (Support for Patient Context-driven Assessments).	34930
					9. The system MAY track and retain the name, version, and data field labels (i.e., questions) of the assessment tool used in a patient encounter	34930a
					10. The system MAY provide the ability to link the value of the assessment responses to the related data field label	34930b
DC.2.1.2	F	Support for Patient Context- Driven Assessments EN	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 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	331341
					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	3432
					3. The system SHOULD provide the ability to compare health data and patient context-driven assessments to practice standards in order to prompt additional testing, possible diagnoses, or adjunctive treatment	3433
					4. The system SHOULD provide the ability to correlate assessment data and the data in the patient specific problem list	3434
					5. The system SHALL conform to function DC 2.1.1 (Support for Standard Assessments)	3435
					6. The system SHALL conform to function DC.1.5 (Manage Assessments)	3436

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					7. The system SHOULD conform to function DC.1.4.3 (Manage Problem List)	3437
DC.2.1.3	F	Support for Identification of Potential Problems and Trends EN	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 (e.g. , lab results), it is important to be able to identify potential problems and trends that may be patient-specific, given the 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.	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.	3438
					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.	3439
					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.	3540
					4. The system SHOULD provide the ability to configure rules defining abnormal trends.	3541
					5. The system SHOULD provide the ability to -prompt the provider with abnormal trends.	3542
					6. The system SHOULD prompt the provider for additional assessments, testing or adjunctive treatment.	3543
					7. The system SHOULD conform to function DC.1.8.6 (Manage Documentation of Clinician Response to Decision Support Prompts).	3544
					8. The system MAY provide the ability to integrate health information contained in the record with appropriate teaching materials.	3545
					9. The system SHOULD conform to function DC 2.2.1.2 (Support for Context-sensitive Care Plans, Guidelines, Protocols).	3546
DC.2.1.4	F	Support for Patient and Family Preferences EN	Statement: Support the integration of patient and family preferences into clinical decision support. Description: Decision support functions should permit consideration of	DC.1.1.4 DC.1.6.1 DC.1.6.2	1. The system SHALL conform to DC.1.3.1 (Manage Patient and Family Preferences).	347357
					2. The system SHALL provide for the ability to capture and manage patient and family preferences as they pertain to current treatment plans.	3548

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
			patient/family preferences and concerns, such as with language, religion, culture, 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.1.6.3 DC.1.11.1 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. 4. The system SHOULD provide the ability to compare care guidelines and options relating to documented patient and family preferences, including standards of practice. 5. The system SHOULD prompt the provider for testing and treatment options based on patient and family preferences and provide the ability to compare to standard practice. 6. The system MAY provide the ability to integrate preferences with appropriate teaching materials. 7. The system SHOULD provide the ability to integrate necessary documentation of preferences, such as living wills, specific consents or releases. 8. The system SHALL conform to function DC.1.3.2 (Manage Patient Advance Directives).	3549 3650 3651 3652 3653 3654
DC.2.2	H	Care and Treatment Plans, Guidelines and Protocols EN		DC.1.2	1. The system SHALL conform to function IN.1.9 (Patient Privacy and Confidentiality). 2. The system SHALL conform to function IN.2.2 (Auditable Records).	3655 3656
DC.2.2.1	H	Support for Condition Based Care and Treatment Plans, Guidelines, Protocols EN			1. The system SHOULD conform to function IN.1.4 (Patient Access Management). 2. The system SHOULD conform to function IN.3 (Registry and Directory Services).	3657 3658
DC.2.2.1.1	F	Support for Standard Care Plans, Guidelines, Protocols EN	Statement: Support the use of appropriate standard care plans, guidelines and/or protocols for the management of specific conditions. Description: Before they can be	DC 1.6.1 DC.2.5.1	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.	3659

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
			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.		2. The system MAY provide the ability to create and use site-specific care plans, protocols, and guidelines.	3760
					3. The system MAY provide the ability to make site-specific modifications to standard care plans, protocols, and guidelines obtained from outside sources.	3761
					4. The system SHOULD identify, track and provide alerts, notifications and reports about variances from standard care plans, guidelines and protocols.	3762
					5. The system SHALL conform to DC.2.2.1.2 (Support for Context-Sensitive Care Plans, Guidelines, Protocols).	3763
					6. The system SHALL conform to DC.2.1.1 (Support for Standard Assessments).	3764
DC.2.2.1.2	F	Support for Context-Sensitive Care Plans, Guidelines, Protocols EN	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 DC.2.3.1.2 DC.2.5.1 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.	3765
					2. The system MAY provide the ability to capture care processes across the continuum of care.	3766
					3. The system MAY present care processes from across the continuum of care.	3767
					4. The system MAY provide the ability to document the choice of action in response to care plan suggestions.	3768
					5. The system SHOULD identify, track and provide alerts, notifications and reports about variances from standard care plans, guidelines and protocols.	3769
					6. The system SHALL conform to function DC.2.2.1.1 (Support for Standard Care Plans, Guidelines, Protocols).	3870
					7. The system SHALL conform to function DC.2.1.1 (Support for Standard Assessments).	3871
					8. The system SHALL conform to function DC.2.1.2 (Support for Patient Context-Driven Assessments).	3872
DC.2.2.2	F	Support Consistent Healthcare Management of Patient Groups or	Statement: Provide the ability to identify and consistently manage healthcare, over time and across	DC.2.2.1.2 DC.3.2.3	1. The system SHALL conform to DC.2.2.1.2 (Support for Context-Sensitive Care Plans, Guidelines, Protocols).	3873

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
		Populations EN	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, 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. The system may also Include ability to identify groups of patients based on clinical observations or lab test results and assist in initiating a follow-up or recall for selected patients.	S.2.2.2 IN.2.2 IN.6	<p>2. The system SHALL provide the ability to identify patients eligible for healthcare management protocols based on criteria identified within the protocol.</p> <p>3. The system SHOULD provide the ability to include or exclude a patient from an existing healthcare management protocol group.</p> <p>4. The system SHOULD provide the ability to audit compliance of selected populations and groups that are the subjects of healthcare management protocols.</p> <p>5. The system SHALL conform to function S.2.2.2 (Standard Report Generation).</p> <p>6. The system SHOULD conform to function IN.3 (Registry and Directory Services).</p> <p>7. The system MAY provide the ability to identify groups of patients based on clinical observations or lab test results</p> <p>8. The system MAY provide the ability to support initiating a follow-up or recall for selected patients</p>	<p>3874</p> <p>3875</p> <p>3876</p> <p>3877</p> <p>3878</p> <p>3878a</p> <p>378b388b</p>

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
DC.2.2.3	F	Support for Research Protocols Relative to Individual Patient Care Optional	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 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	1. The system SHALL provide the ability to present protocols for patients enrolled in research studies.	3879
					2. The system SHALL provide the ability to maintain research study protocols.	3980
					3. The system SHOULD conform to function S.3.3.1 (Enrollment of Patients), to enable participation in research studies.	3981
					4. The system SHOULD provide the ability to identify and track patients participating in research studies.	3982
					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.	3983
					6. The system SHALL conform to function S.2.2.2 (Standard Report Generation).	3984
					7. The system SHOULD conform to function IN.1.4 (Patient Access Management).	3985
					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).	3986
DC.2.2.4	F	Support Self-Care EN	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	DC.1.1.4 DC.1.11.1 S.3.7.1 S.3.7.2 S.3.7.3 IN.1.4	1. The system SHALL provide the ability to present patient guidance and reminders appropriate for self-management of clinical conditions.	3987
					2. The system SHALL provide the ability to manage and/or develop patient guidance and reminders related to specific clinical conditions.	3988
					3. The system SHOULD conform to function DC.1.1.3.2 (Capture of Patient Originated Data).	3989

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			tests, and clinical check ups; recommendations about nutrition, physical activity, tobacco use, etcetera; 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	IN.1.9 IN.6	4. The system SHOULD conform to function DC.1.3.1 (Manage Patient and Family Preferences). 5. The system SHOULD conform to function IN.1.4 (Patient Access Management). 6. The system SHOULD conform to function IN.3 (Registry and Directory Services).	40390 40391 40392
DC.2.3	H	Medication and Immunization Management EN			1. The system SHALL conform to function IN.1.9 (Patient Privacy and Confidentiality). 2. The system SHALL conform to function IN.2.2 (Auditable Records). 3. The system SHOULD conform to function IN.3 (Registry and Directory Services).	40393 40394 40395
DC.2.3.1	H	Support for Medication and Immunization Ordering EN				40396
DC.2.3.1.1	F	Support for Drug Interaction Checking EN	Statement: Identify drug interaction warnings at the time of medication ordering. Description: The clinician is alerted to drug-drug, drug-allergy, and drug-food, interactions drug-herbal, drug-dietary supplements 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	S.3 IN.2.4 IN.6 DC.1.8.6	1. The system SHALL check for and alert providers to interactions between prescribed drugs and medications on the current medication list. 2. The system SHALL relate medication allergies to medications to facilitate allergy checking decision support for medication orders. 3. The system SHOULD SHALL provide the ability to document that a provider was presented with and acknowledged -a drug interaction warning. 4. The system SHALL provide the ability to prescribe a medication despite alerts for interactions and/or allergies being present. 5. The system MAY SHALL provide the ability to set the severity level at which warnings should be displayed.	40397 40398 40399 4100 4101

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			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.		6. The system SHOULD provide the ability to check for duplicate therapies.	4102
					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.	4103
					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.	4104
					9. The system SHOULD SHOULD check for drug-lab interactions, to indicate to the prescriber <u>clinician</u> that certain lab test results may be impacted by a patient's drugs.	4105
					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.	4106
					11. The system SHOULD SHALL identify contraindications between a drug and patient conditions at the time of medication ordering.	4107
					12. The system SHOULD provide a consenting function that would allow access to restricted medication, i.e. Risk Evaluation and Mitigation Strategy (REMS).	NEW 418
					13. The system SHOULD check for and alert providers to interactions between prescribed drugs and herbal and/or dietary supplements and medications on the current medication list.	NEW 419
DC.2.3.1.2	F	Support for Patient Specific Dosing and Warnings EN	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 e.g. pregnancy, breast-feeding or occupational risks, hepatic or renal	DC.2.2.1.2 DC.2.3.1.1 IN.6	1. The system SHALL provide the ability to identify an appropriate drug dosage range <u>(for a single and/or daily dose)</u> , specific for each known patient condition and parameter at the time of medication ordering.	420408
					2. The system SHALL provide the ability to automatically alert the provider if contraindications to the ordered dosage range <u>(for a single and/or daily dose)</u> are identified.	42109
					3. The system SHALL provide the ability for the provider to override a drug dosage warning.	42240

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			insufficiency. The preferences of the patient may also be presented e.g. reluctance to use an antibiotic. Additional patient parameters, such as age, gestation, genetic disposition, Height, Weight, Body Surface Area (BSA), shall also be incorporated. . May be proactive and/or reactive.		<p>4. The system SHOULD provide the ability to document reasons for overriding a drug alert or warning at the time of ordering.</p> <p>5. The system SHOULD transmit documented reasons for overriding a drug alert to the pharmacy to enable communication between the clinician and the pharmacist.</p> <p>6. The system SHOULD conform to function IN.1.4 (Patient Access Management).</p> <p>7. IF the maximum daily doses are known, THEN the system SHALL apply the maximum dose per day in dosing decision support.</p> <p>8. The system SHOULD compute drug doses, based on appropriate dosage ranges, using the patient's body weight.</p> <p>9. The system SHOULD provide the ability to specify an alternative "dosing weight" for the purposes of dose calculation.</p> <p>10. The system SHOULD perform drug dosage functions using any component of a combination drug (e.g., acetaminophen-hydrocodone).</p> <p>11. The system SHOULD provide the ability to record the factors to be used to calculate the future dose for a given prescription.</p>	<p>42314</p> <p>42442</p> <p>42543</p> <p>42644</p> <p>42745</p> <p>42846</p> <p>42947</p> <p>43048</p>
DC.2.3.1.3	F	Support for Medication Recommendations EN	<p>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.</p> <p>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</p>	DC 2.3.1.2 S.3.3.2 IN.6	<p>1. The system SHOULD conform to function DC 2.3.1.2 (Support for Patient-Specific Dosing and Warnings).</p> <p>2. The system SHOULD present recommendations for medication regimens based on findings related to the patient diagnosis.</p> <p>3. The system SHALL present alternative treatments in medications on the basis of practice standards, cost, formularies, or protocols.</p> <p>4. The system SHOULD present suggested lab monitoring as appropriate to a particular medication.</p>	<p>43149</p> <p>43220</p> <p>43324</p> <p>43422</p>

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			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.		5. The system SHOULD conform to function IN.1.4 (Patient Access Management).	43523
DC.2.3.2	F	Support for Medication and Immunization Administration EN	<p>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.</p> <p>Description: To reduce medication errors at the time of administration of a medication, the patient is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by-product of this checking; administration details and additional patient information, such as injection site, vital signs, and pain assessments, are captured. 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.</p>	DC.1.3.3 DC.1.7.2 DC.1.10.1 DC.2.7.1 S.1.4.1 S.2.2.2 S.3.7.1 IN.2.3 IN.2.4 IN.6	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.	43624
					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.	43725
					3. The system SHOULD alert providers to potential medication administration errors at the point of medication administration.	43826
					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.	43927
					5. IF required by the EHR user’s scope of practice, THEN the system SHALL 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).	44028
					6. The system MAY generate documentation of medication or immunization administration as a by-product of verification of patient, medication, dose, route and time.	44129
					7. The system SHOULD prompt or remind providers regarding the date/time range for timely administration of medications.	44230

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					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.	44334
					9. The system MAY conform to function DC.2.7.1 (Access Healthcare Guidance) and provide to the ability for a provider to access drug monograph information.	44432
DC.2.4	H	Orders, Referrals, Results and Care Management EN			1. The system SHALL conform to function IN.1.9 (Patient Privacy and Confidentiality).	44533
					2. The system SHALL conform to function IN.2.2 (Auditable Records).	44634
					3. The system SHOULD conform to function IN.3 (Registry and Directory Services).	44735
DC.2.4.1	F	Create Order Set Templates Optional	Statement: Create, capture, maintain and display order set templates based on patient data or preferred standards or other criteria. 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.	DC.1.9.3 S.2.2.2 S.3.7.1 IN.1.1 IN.1.2 IN.1.3 IN.6	1. The system SHALL provide the ability to create order set templates.	44836
					2. The system SHALL provide the ability to maintain order set templates, including version control.	44937
					3. The system MAY provide the ability to create order set templates from provider input.	45038
					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.	45139
					5. The system MAY provide the ability to create order set templates for known conditions for a particular disease.	45240
					6. The system SHALL provide the ability to present the order set templates to the provider.	45344
					7. The system MAY record the basis of the practice standards or criteria for the creation of the order set templates.	45442
					8. The system MAY provide the ability to relate order set templates to aid decision support for certain diseases.	45543
					9. The system SHALL conform to DC.1.7.3 (Manage Order Sets).	45644

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DC.2.4.2	F	Support for Non-Medication Ordering EN	<p>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.</p> <p>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.</p> <p>Non-medication orders include orders such as:</p> <ul style="list-style-type: none"> supplies such as 4x4's and ACE bandages non-medical devices such as TTY phones for the hearing impaired groups of supplies or kits common to an organization simple durable medical equipment (DME) such as crutches or walkers complex DME such as wheelchairs and hospital beds therapies and other services that may require a referral and/or an authorization for insurance coverage 	S.3.3.3 IN.6	1. The system SHALL identify required order entry components for non-medication orders.	45745
					2. The system SHALL present an alert at the time of order entry, if a non-medication order is missing required information.	45846
					3. The system SHOULD present an alert via warnings of orders that may be inappropriate or contraindicated for specific patients at the time of provider order entry.	45947
					4. The system SHOULD conform to function S.3.3.3. (Service Authorizations).	46048

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
DC.2.4.3	F	Support for Result Interpretation EN	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 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.	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.	46149
					2. The system SHOULD provide the ability to trend results.	46250
					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).	46354
					4. The systems MAY provide the ability to capture and report the lab value that triggered the display of alerts and flags (e.g., a value to trigger an HH or LL flag).	46354a
DC.2.4.4	H	Support for Referrals EN				46452
DC.2.4.4.1	F	Support for Referral Process EN	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.	46553
					2. The system SHALL provide the ability to include test and procedure results with a referral.	46654
					3. The system MAY provide the ability to include standardized or evidence based protocols with the referral.	46755
					4. The system SHOULD allow clinical, administrative data, and test and procedure results to be transmitted to and from the referral clinician.	46856
					5. The system SHALL conform to function S.2.2.1 (Health Record Output).	46957
DC.2.4.4.2	F	Support for Referral Recommendations	Statement: Evaluate patient data and recommend that a patient be referred based on the specific patient's	S.3.7.1 IN.6	1. The system SHALL present recommendations for potential referrals based on diagnosis(es).	47058

ID#	Type	Name	Statement/Description	See Also	Conformance Criteria	Row #
		EN	healthcare data. 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.		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). 3. The system SHOULD conform to IN.1.4 (Patient Access Management).	47159 47260
					4. The system SHALL provide the ability to receive patient referrals based on patient's condition.	NEW 473
DC.2.4.5	H	Support for Care Delivery Optional				47461
DC.2.4.5.1	F	Support for Safe Blood Administration Optional	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. 2. The system SHALL capture validation of the correct matching of the patient to the blood product. 3. The system SHALL capture the blood product number, amount, route and time of administration. 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. 5. The system SHALL conform to function S.2.2.1 (Health Record Output).	47562 47663 47764 47865 47966
DC.2.4.5.2	F	Support for Accurate Specimen Collection Optional	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	S.1.4.1 S.2.2.1 IN.1.6 IN.1.7	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.	48067

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			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.	IN.1.9 IN.2.3 IN.2.4 IN.6	2. The system SHALL report variation between the type of specimen order placed and actual specimen received. 3. The system SHALL capture the details of specimen collection. 4. The system SHALL conform to function S.2.2.1 (Health Record Output). 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.	48168 48269 48370 48474
DC.2.5	H	Support for Health Maintenance: Preventive Care and Wellness EN			1. The system SHOULD conform to function IN.1.4 (Patient Access Management). 2. The system SHALL conform to function IN.1.9 (Patient Privacy and Confidentiality). 3. The system SHALL conform to function IN.2.2 (Auditable Records). 4. The system SHOULD conform to function IN.3 (Registry and Directory Services).	48572 48673 48774 48876
DC.2.5.1	F	Present Alerts for Preventive Services and Wellness EN	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. 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, medication reminders , adult and well child care, age and gender appropriate screening exams, such as PAP smears. The provider may wish to provide reminders to the patient based on the alert.	DC.1.6.2 DC.2.2.1.1 DC.2.2.1.2 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). 2. The system SHOULD provide the ability to modify the established criteria that trigger the alerts. 3. The system SHOULD present recommended preventative or wellness services needed based upon clinical test results. 4. The system SHALL present alerts to the provider of all patient specific preventive services that are due. 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. 6. The system MAY provide the ability to produce a history of all alerts that were generated for the patient in the record.	48976 49977 49178 49279 49380 49484

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DC.2.5.2	F	Notifications and Reminders for Preventive Services and Wellness EN	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, medication reminders , 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.	49582
					2. The system SHOULD capture a history of notifications.	49683
					3. The system SHOULD provide the ability to track overdue preventive services.	49784
					4. The system SHOULD provide notification of overdue preventative services in the patient record.	49885
					5. The system MAY provide the ability to configure patient notifications (such as repetitions or timing of the activity).	49986
					6. The system SHOULD provide the ability to update content of notifications, guidelines, reminders and associated reference materials.	500487
					7. The system MAY provide the ability to manage the lifecycle of the states of the notifications and reminders.	501488
DC.2.6	H	Support for Population Health EN			1. The system SHALL conform to function IN.1.9 (Patient Privacy and Confidentiality).	502489
					2. The system SHALL conform to function IN.2.2 (Auditable Records).	450390
DC.2.6.1	F	Support for Epidemiological Investigations of Clinical Health Within a Population. EN	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	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	1. The system SHALL provide the ability to aggregate patient information based on user-identified criteria.	450494
					2. The system SHALL apply local privacy and confidentiality rules when assembling aggregate data to prevent identification of individuals by unauthorized parties.	505492
					3. The system SHOULD provide the ability to use any demographic or clinical information as criteria for aggregation.	450693

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			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 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.	IN.2.3 IN.2.4	<p>4. The system SHOULD present aggregate data in the form of reports for external use.</p> <p>5. The system SHOULD provide the ability to save report definitions for later use.</p> <p>6. The system MAY present aggregate data in an electronic format for use by other analytical programs.</p> <p>7. The system MAY provide the ability to derive statistical information from aggregate data.</p> <p>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).</p>	<p>494507</p> <p>495508</p> <p>509496</p> <p>497510</p> <p>498511</p>
DC.2.6.2	F	Support for Notification and Response EN	<p>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.</p> <p>Description: After receiving a notice of a health risk within a cared-for population from public health authorities or other external authoritative sources:</p> <ol style="list-style-type: none"> 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. 	<p>S.1.3.6</p> <p>S.2.2.2</p> <p>S.3.7.1</p> <p>S.3.7.4</p> <p>IN.1.6</p> <p>IN.1.7</p> <p>IN.2.4</p> <p>IN.3.1</p> <p>IN.3.2</p> <p>IN.4.1</p> <p>IN.4.2</p>	<p>1. The system SHALL provide the ability to identify individual care providers or care managers within a cared for population.</p> <p>2. The system SHALL provide the ability to prepare a response notification to the care providers or care managers.</p> <p>3. The system SHALL provide the ability to capture notification of a health risk within a cared-for population from public health authorities or other external authoritative sources as either free-text or a structured message.</p> <p>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.</p>	<p>512499</p> <p>51399</p> <p>51404</p> <p>51592</p>

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			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. 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.	IN.4.3 IN.5.1 IN.5.2 IN.5.4	5. The system MAY provide the ability to notify patients, directly or indirectly, who are described by the health risk alert. 6. The system SHOULD present suggestions to the care provider indicating an appropriate course of action. 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 population in accordance with scope of practice, organizational policy and jurisdictional law. 8. The system SHOULD conform to function IN.3 (Registry and Directory Services).	51603 51704 51805 51906
DC.2.6.3	F	Support for Monitoring Response Notifications Regarding a Specific Patient's Health EN	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. 2. The system SHALL notify appropriate care providers of specific patient actions required by a health risk alert. 3. The system SHALL provide the ability to identify those patients who have not received appropriate action in response to a health risk alert. 4. The system SHOULD provide the ability to report on the omission of an appropriate response to the health risk alert in specific patients. 5. The system SHOULD conform to function IN.1.4 (Patient Access Management). 6. The system SHOULD conform to function IN.3 (Registry and Directory Services).	52007 52108 52209 52340 52444 52542
DC.2.7	H	Support for Knowledge Access EN			1. The system SHOULD conform to function IN.3 (Registry and Directory Services)	52643

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DC.2.7.1	F	Access Healthcare Guidance EN	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	52744
					2. The system SHOULD provide the ability to access evidenced-based documentation appropriate for the care provider to render a timely judgment.	54528
					3. The system MAY provide the ability to access external evidence-based documentation.	516529
					4. The system SHALL conform to function DC.2.2.1.1 (Support for Standard Care Plans, Guidelines, Protocols).	530517
					5. The system SHOULD conform to function IN.1.4 (Patient Access Management).	53118
DC.2.7.2	F	Patient Knowledge Access EN	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	DC.3.2.4 DC.3.4.9 S.3.7.1 S.3.7.2 S.3.7.4	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.	53249
					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.	53329

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			visit, identify treatment options, or other health information needs. The 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.1.4 IN.5.1 IN.5.3 IN.5.4 IN.6	3. The system MAY provide the ability to access patient educational information from external sources. 4. IF the information is external-based, THEN the system MAY provide the ability to identify links specific to the information. 5. The system SHALL conform to function IN.1.4 (Patient Access Management). 6. The system SHALL conform to function IN.1.9 (Patient Privacy and Confidentiality). 7. The system SHALL conform to function IN.2.2 (Auditable Records).	53424 53522 53623 53724 53825
DC.3	H	Operations Management and Communication EN			1. The system SHALL conform to function IN.1.1 (Entity Authentication). 2. The system SHALL conform to function IN.1.2 (Entity Authorization). 3. The system SHALL conform to function IN.1.3 (Entity Access Control). 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. 5. IF the system exchanges data with other sources or destinations of data, THEN the system SHALL conform to function IN.1.7 (Secure Data Routing) to ensure that the exchange occurs only among authorized senders and "receivers". 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. 7. The system SHALL conform to function IN.1.9 (Patient Privacy and Confidentiality). 8. The system SHALL conform to function IN.2.1 (Data Retention, Availability and Destruction). 9. The system SHALL conform to function IN.2.2 (Auditable Records).	53926 54027 54128 54229 54330 54434 54532 54633 54734

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					10. The system SHOULD conform to function IN.2.3 (Synchronization).	54835
					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.	54936
					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.	55037
					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.	55138
					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.	55239
					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.	55340
					16. The system SHOULD conform to function IN.4.3 (Terminology Mapping).	55441
					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.	55542

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					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.	55643
					19. The system SHOULD conform to function IN.5.3 (Standards-based Application Integration).	55744
					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.	55845
					21. The system SHOULD conform to function IN.6 (Business Rules Management).	55946
					22. The system SHOULD conform to function IN.7 (Workflow Management).	56047
DC.3.1	H	Clinical Workflow Tasking EN	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,			56148

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			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 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	Clinical Task Assignment and Routing EN	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.	S.1.3.1a S.1.3.5 IN.6	1. The system SHALL provide the ability for users to create manual clinical tasks.	549562
					2. The system SHALL provide the ability to automate clinical task creation.	56359
					3. The system SHALL provide the ability to manually modify and update task status (e.g. created, performed, held, canceled, pending, denied, and resolved).	56451
					4. The system MAY provide the ability to automatically modify or update the status of tasks based on workflow rules.	56552

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			For example, after receiving communication (e.g. a phone call or e-mail) from a patient, the triage nurse routes or assigns a task to return the patient's call to the physician who is on call. 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. 6. The system MAY provide the ability to manage workflow task routing to multiple individuals or roles in succession and/or in parallel. 7. The system MAY provide the ability to prioritize tasks based on urgency assigned to the task. 8. The system MAY provide the ability to restrict task assignment based on appropriate role as defined by the entity. 9. The system MAY provide the ability to escalate clinical tasks as appropriate to ensure timely completion. 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/sent/received the data. 11. The system SHOULD conform to function IN.3 (Registry and Directory Services).	56653 56754 56855 56956 57057 57158 57259
DC.3.1.2	F	Clinical Task Linking EF 2015	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 contact information, or	S.1.3.1 S.1.4.1 S.1.4.2 S.1.4.4 S.1.6 S.1.7	1. The system SHALL provide the ability to link a clinical task to the component of the EHR required to complete the task.	57360

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			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 phone calls.	IN.2.3 IN.7	2. The system SHALL conform to function IN.1.5 (Non-Repudiation).	557464
DC.3.1.3	F	Clinical Task Tracking EN	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 show test results that have not been reviewed by the ordering provider based on an interval appropriate to the care setting.	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.	57562
					2. The system SHALL provide the ability to notify providers of the status of tasks.	57663
					3. The system SHOULD provide the ability to sort clinical tasks by status.	57764
					4. The system MAY provide the ability to present current clinical tasks as work lists.	57865
					5. The system SHOULD provide the ability to define the presentation of clinical task lists.	57966
					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/sent/received the data.	58067
					7. The system SHOULD conform to function IN.3 (Registry and Directory Services).	58168
DC.3.2	H	Support Clinical Communication EN	Statement: Description: Healthcare requires secure communications among various participants: patients, doctors, nurses, chronic disease care managers, pharmacies, laboratories, payers,		1. The system SHOULD conform to function IN.3 (Registry and Directory Services).	58269

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			consultants, and etcetera. 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. 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	Support for Inter-Provider Communication EN	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	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	1. The system SHALL provide the ability to document in the patient record verbal/telephone communication between providers.	570583
					2. The system SHALL provide the ability to incorporate scanned documents from external providers into the patient record.	58474

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			(for example, fulfillment of an injection while the patient is in the exam room), 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 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 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.	IN.1.5 IN.1.6 IN.1.7 IN.1.9 IN.2.2. IN.3.1 IN.5.1 IN.5.2	<p>3. The system MAY provide the ability to communicate using real-time messaging.</p> <p>4. The system SHOULD provide the ability to communicate clinical information (e.g. referrals) via email or other standard electronic means.</p> <p>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.</p> <p>6. The system SHALL conform to function IN.1.5 (Non-Repudiation).</p>	<p>58572</p> <p>58673</p> <p>58774</p> <p>58875</p>
DC.3.2.2	F	Support for Provider - Pharmacy Communication EN	<p>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.</p> <p>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</p>	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	<p>1. The system SHALL conform to function DC.1.7.1 (Manage Medication Orders) and provide the ability to order medications.</p> <p>2. The system SHALL electronically communicate orders between the prescriber, provider and pharmacy, as necessary, to initiate, change, or renew a medication order.</p> <p>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.</p> <p>4. The system SHOULD provide the ability to electronically communicate current realm-specific standards to pharmacies.</p>	<p>58976</p> <p>59077</p> <p>59178</p> <p>59279</p>

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			tasks. The transmission of prescription data between systems should conform to realm acceptable messaging standards. 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. These messaging standards might be generic clinical communication standards, internationally agreed pharmacy messages, or nationally defined messages. Informative examples: - HL7 Clinical Document Architecture Release 2 - ISO/EN 13606 Electronic Health Record Communication - CEN ENV 13607:2000. Health informatics. Messages for the exchange of information on medicine prescriptions - X12N healthcare transactions US realm: National Council for Prescription Drug Programs (NCPDP) - Canadian realm: National Electronic Claims Standard (NeCST)	IN.5.1 IN.5.2 IN.5.3 IN.5.4 IN.6 IN.7	5. The system MAY provide the ability for providers and pharmacies to communicate clinical information via e-mail or other electronic means, on both general and specific orders. 6. The system MAY provide the ability to use secure real-time messaging. 7. The system MAY provide the ability to include workflow tasks as part of communication to the provider. 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/sent/received the data.	59389 59484 59582 59683
DC.3.2.3	F	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,	DC.1.1.3 DC.1.11.3 DC.2.2.2	1. The system SHALL provide the ability to capture documentation of communications between providers and patients and/ or the patient representatives. 2. The system SHALL provide the ability to incorporate scanned documents.	59784 59885

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		EN	capturing the nature and content of electronic communication, or the time and details of other communication. Examples: <ul style="list-style-type: none"> 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. 	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	3. The system SHALL provide the ability to document communication originating with the patient or patient representative (e.g. date, entity, details of communication). 4. The system SHOULD provide the ability to communicate between providers and patients or their representative using a secure internet connection. 5. The system SHALL provide the ability to manage documentation regarding family member or patient representative authorizations to receive patient related health information. 6. The system SHOULD alert providers to the presence of patient or patient representative originated communications. 7. The system SHOULD provide the ability to alert patients or patient representative to provider absences (e.g. vacations) and recommend rerouting of the information or request. 8. The system MAY provide the ability to notify providers of events and new treatment options. 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. 10. The system SHALL conform to function IN.1.4 (Patient Access Management). 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/sent/received the data. 12. The system MAY provide the ability to support communication and capture documentation of communications between providers and patient groups.	59986 600587 601588 602589 603590 604594 605592 606593 607594 607594a
DC.3.2.4	F	Patient, Family and Care Giver Education	Statement: Facilitate access to educational or support resources pertinent to, and usable by, the patient	DC.2.1.4 DC 3.2.3	1. The system SHALL provide the ability to access to a library of educational material for medication , health concerns, conditions, and/or diagnosis.	608595

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		EN	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 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.	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	2. The system SHALL provide the ability to communicate applicable educational materials to the patient and/or patient representative. 3. The system MAY SHOULD provide the ability to deliver multilingual educational material. 4. The systems MAY SHOULD provide the ability to deliver patient educational materials using alternative modes to accommodate patient sensory capabilities. 5. The system MAY provide the ability to access to external educational materials. 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. 7. The system MAY SHOULD provide the ability to document who received the educational material provided, the patient, or the patient representative. 8. The system MAY SHOULD provide the ability to document that the educational material was reviewed with the patient and/or patient representative and their comprehension of the material. 9. The system MAY SHOULD provide the ability to identify age-appropriate and/or reading-ability appropriate educational materials for the patient and/or patient representative. 10. The system MAY provide the ability for direct access to the educational material available, by patients and/or patient representatives. 11. The system SHALL conform to function IN.1.4 (Patient Access Management). 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/sent/received the data.	609596 610597 611598 612599 61300 61401 61502 61603 61704 61805 61906

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DC.3.2.5	F	Communication with Medical Devices Optional	Statement: Support communication and presentation of data captured from medical and medication monitoring 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, and	IN.1.1 IN.1.2 IN.1.3 IN.1.6 IN.1.7 IN.1.9 IN.4.1 IN.4.2	1. The system SHALL provide the ability to collect accurate electronic data from medical devices according to realm-specific applicable regulations and/or requirements.	62007
					2. The system SHOULD provide the ability to present information collected from medical devices as part of the medical record as appropriate.	62108

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			bar coded artifacts (medicine, immunizations, demographics, history, and identification).	IN.4.3 IN.5.1 IN.5.2 IN.5.3 IN.7 DC.1.8.1	3. The system SHOULD conform to function IN.1.4 (Patient Access Management).	62209 707 708

