

HL7 ID	Function Name	Function Statement	A4 Health Systems	AcerMed	Companion Technologies	DOCS, Inc.	Dr Notes	e-MDs	GE Healthcare	MediTech	Misys Healthcare	NextGen	North Base	OmniMD	Outcome Sciences	PMSI	Solventus
DC.1.1	Health information capture, management, and review																
DC.1.1.1	Identify and locate a patient record	Maintain and identify a single patient record for each patient.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
DC.1.1.2	Manage patient demographics	Capture and maintain demographic information that is reportable and, where appropriate, trackable over time.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
DC.1.1.3	Manage summary lists	Create and maintain patient-specific summary lists.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
DC.1.1.3.1	Manage problem list	Create and maintain patient-specific problem lists.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.1.1.3.2	Manage medication list	Create and maintain patient-specific medication lists.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
DC.1.1.3.3	Manage allergy and adverse reaction list	Create and maintain patient-specific allergies and reactions.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
DC.1.1.4	Manage Patient History	Capture, review, and manage medical, procedural, social, and family history including the capture of pertinent negative histories, patient-reported or externally available patient clinical history.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
DC.1.1.5	Summarize health record	Present a chronological, filterable, comprehensive review of the patient's entire clinical history, subject to confidentiality constraints.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.1.1.6	Manage clinical documents and notes	Create, addend, and authenticate transcribed or directly-entered clinical documentation and notes.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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DC.1.1.7	Capture key health data	Capture, manage, and review key health data by a variety of users.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
DC.1.1.7.1	Capture external clinical documents	Incorporate clinical documents and notes from external sources.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.1.1.7.2	Capture patient-originated data	Capture patient-provided and patient-entered clinical data.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes		Yes	Yes
DC.1.2	Care plans, guidelines, and protocols		Yes	Yes		Yes	Yes	Yes		Yes		Yes				Yes	
DC.1.2.1	Present care plans, guidelines, and protocols	Present organizational guidelines for patient care as appropriate to support order entry and clinical documentation.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No		Yes	Yes
DC.1.2.2	Manage patient-specific care plans, guidelines, and protocols.	Provide administrative tools for organizations to build guidelines and protocols for use during patient care.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			Yes	Yes
DC.1.2.3	Manage patient-specific instructions	Generate and record patient-specific instructions related to pre- and post-procedural and post-discharge requirements.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			Yes	Yes
DC.1.3	Medication ordering and management			Yes						Yes		Yes				Yes	Yes
DC.1.3.1	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration by pharmacy and clinical staff.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.1.3.2	Manage medication formularies	Provide information regarding compliance of medication orders with formularies.	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes		No		Yes	No

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DC.1.3.3	Manage medication administration	Present to appropriate clinicians the medications that are to be administered to a patient, under what circumstances, and capture administration details.	Yes	Yes	Yes		No		Yes	Yes	Yes	Yes	Yes	Yes		Yes	No
DC.1.4	Orders, referrals, and results management			Yes				Yes				Yes		Yes		Yes	Yes
DC.1.4.1	Place generic orders	Capture and track orders based on input from specific care providers.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.1.4.2	Order diagnostic tests	Submit diagnostic test orders based on input from specific care providers.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.1.4.3	Manage order sets	Provide order sets based on provider input or system prompt.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.1.4.4	Manage referrals	Enable the origination, documentation and tracking of referrals between care providers or care settings, including clinical and administrative details of the referral.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.1.4.5	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, filtering and comparison.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No		Yes	Yes
DC.1.4.6	Order blood products and other biologics	Communicate with appropriate sources or registries to order blood products or other biologics	No	Yes			No	No	Yes		Yes	No		No		Yes	No
DC.1.5	Consents and authorizations			Yes								Yes		Yes		Yes	No

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DC.1.5.1	Manage consents and authorizations	Create, maintain, and verify patient treatment decisions in the form of consents and authorizations when required during the ordering process.	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	No
DC.1.5.2	Manage patient advanced directives	Capture, maintain and provide access to patient advanced directives	Yes	Yes	Yes		Yes	Yes	Yes	Yes		Yes	Yes	No		Yes	No
DC.2	Clinical Decision Support			Yes								Yes				Yes	
DC.2.1	Health information capture and review			Yes								Yes				Yes	
DC.2.1.1	Support for standard assessments	Offer knowledge-based prompts to support the adherence to care plans, guidelines, and protocols at the point of information capture.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.2.1.2	Support for Patient Context-enabled Assessments	Offer knowledge-based prompts based on patient-specific data at the point of information capture.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes		Yes	Yes
DC.2.1.3	Support for identification of potential problems and trends	Identify specific problems or trends that may lead to significant problems, which may be based on patient data, providing prompts for consideration at the point of information capture.	Yes	Yes	No		Yes	Yes	Yes		Yes	Yes	Yes	No		Yes	No
DC.2.1.4	Patient and family preferences	Capture patient and family preferences at the time of information intake and integrate them into clinical - decision support at all appropriate opportunities.	No	Yes	Yes		Yes	Yes	Yes		Yes	Yes		No		Yes	No
DC.2.2	Care plans, guidelines and protocols			Yes								Yes				Yes	Yes
DC.2.2.1	Support for condition based care plans, guidelines, protocols			Yes				Yes				Yes	Yes			Yes	Yes

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DC.2.2.1.1	Present standard care plans, guidelines, protocols	Identify the appropriate care plans, guidelines and/or protocols for the management of specific conditions.	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No		Yes	Yes
DC.2.2.1.2	Present context sensitive care plans, guidelines, protocols	Identify the appropriate care plans, guidelines and/or protocols for the management of specific conditions that are adjusted to the patient specific profile.	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes		No		Yes	Yes
DC.2.2.1.3	Capture variances from standard care plans, guidelines, protocols	Identify variances from standard care plans, guidelines, and protocols.	No	Yes	No		No	No	Yes		Yes	Yes				Yes	No
DC.2.2.1.4	Support management of patient groups or populations	Provide support for the management of populations of patients that share diagnoses, problems, demographic characteristics, etc.	Yes	Yes	No		No	Yes	Yes	Yes	Yes	Yes	Yes			Yes	Yes
DC.2.2.1.5	Support research protocols	Provide support for the identification of patients for potential enrolment in research protocols and management of patients enrolled in research protocols.	Yes	Yes	No		No	Yes	Yes		Yes	Yes	Yes			Yes	Yes
DC.2.2.1.6	Support self-care	Provide the patient with decision support for self-management of a condition between patient-provider encounters.	No	No	No		Yes	Yes	Yes	Yes	No	Yes	Yes			Yes	Yes
DC.2.3	Medications and medication management			Yes								Yes				Yes	
DC.2.3.1	Support for medication ordering			Yes								Yes				Yes	
DC.2.3.1.1	Drug, food, allergy interaction checking	Identify drug-drug, drug-allergy and drug-food interaction warnings at the point of medication ordering.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes

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DC.2.3.1.2	Patient specific dosing and warnings	Identify drug-condition warnings and present weight/age appropriate dose recommendations	No	No	No	No	Yes	No	Yes	Yes	Yes	Yes		Yes		No	No
DC.2.3.1.3	Medication recommendations	Recommend best practice treatment and monitoring on the basis of cost, local formularies or therapeutic guidelines and protocols	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes		No		Yes	No
DC.2.3.2	Support for medication administration.	Alert providers in real-time to potential administration errors such as wrong patient, wrong drug, wrong dose, wrong route and wrong time in support of medication administration management and workflow.	No	No			Yes	No	Yes		No	Yes				Yes	No
DC.2.4	Orders, referrals, results and care management			Yes								Yes				Yes	Yes
DC.2.4.1	Support for non-medication ordering	Identify necessary order entry components for non-medication orders that make the order pertinent, relevant and resource conservative at the time of provider order entry; and flag any inappropriate orders based on patient profile.	No	Yes	No		Yes	Yes	Yes		No	Yes	Yes			Yes	Yes
DC.2.4.2	Support for result interpretation	Evaluate results and notify provider of results within the context of the patient's clinical data.	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes		No		Yes	Yes
DC.2.4.3	Support for referrals			Yes								Yes		Yes		Yes	Yes
DC.2.4.3.1	Support for referrals	Evaluate referrals within the context of a patient's clinical data.	Yes	Yes	Yes	Yes	Yes	Yes/No	Yes	Yes	Yes	Yes		Yes		Yes	Yes

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DC.2.4.3.2	Support for referral recommendations	Evaluate patient data and suggest appropriate referrals.	No	Yes	No		No	No	Yes		Yes	Yes				Yes	No
DC.2.4.4	Support for Care Delivery											Yes				Yes	
DC.2.4.4.1	Support for safe blood administration	Alert providers in real-time to potential blood administration errors such as wrong blood, wrong cross match, wrong source, wrong date and time, and wrong patient.	No	Yes			No	No	No		No	No				No	No
DC.2.4.4.2	Support for accurate specimen collection	Alert providers in real-time to potential specimen collection errors, such as wrong patient, wrong specimen type, wrong collection means, and wrong date and time.	No	No			No	No	No		No	No				Yes	No
DC.2.5	Support for Health Maintenance: Preventive Care and Wellness			Yes								Yes				Yes	No
DC.2.5.1	Alerts preventive services and wellness	Identify patient specific suggestions/reminder s, screening tests/exams, and other preventive services in support of routine preventive and wellness patient care standards.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
DC.2.5.2	Notifications for preventive services and wellness	Notify the patient and/or appropriate provider of those preventive services, tests, behavioral actions that are due or overdue between patient-provider encounters.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
DC.2.6	Support for population health			Yes								Yes		No		Yes	

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DC.2.6.1	Support for clinical health state monitoring within a population.	Support clinical health state monitoring of aggregate patient data for use in identifying health risks from the environment and/or population.	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No		Yes	Yes
DC.2.6.2	Support for notification and response	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.	Yes	Yes	Yes	Yes	No	Yes	Yes		Yes	Yes	Yes	No		Yes	Yes
DC.2.6.3	Support for monitoring and appropriate notifications regarding an individual patient's health	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.	Yes	Yes	Yes	Yes	No	Yes	Yes		Yes	No		No		Yes	Yes
DC.2.7	Support for knowledge access			Yes								Yes				Yes	
DC.2.7.1	Access clinical guidance	Provide relevant evidence-based information and knowledge to the point of care for use in clinical decisions and care planning	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	No
DC.2.7.2	Patient knowledge access	Enable the accessibility of reliable information about wellness, disease management, treatments, and related information that is relevant for a specific patient.	Yes	Yes	Yes		No	Yes	Yes	Yes	Yes	Yes	Yes			Yes	No
DC.3	Operations Management and Communication			Yes	Yes		Yes					Yes				Yes	

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DC.3.1	Clinical workflow tasking	Schedule and manage clinical tasks with appropriate timeliness.	Yes	Yes	Yes		Yes	Yes	Yes		Yes	Yes	Yes			Yes	
DC.3.1.1	Clinical task assignment and routing	Assignment, delegation and/or transmission of tasks to the appropriate parties.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.3.1.2	Clinical task linking	Linkage of tasks to patients and/or a relevant part of the electronic health record.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.3.1.3	Clinical task tracking	Track tasks to guarantee that each task is carried out and completed appropriately.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.3.1.3.1	Clinical task timeliness tracking	Track and/or report on timeliness of task completion.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
DC.3.2	Clinical communication			Yes								Yes				Yes	
DC.3.2.1	Inter-provider communication	Support secure electronic communication (inbound and outbound) between providers to trigger or respond to pertinent actions in the care process, document non-electronic communication (such as phone calls, correspondence or other encounters) and generate paper message artifacts where appropriate.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes		Yes	Yes
DC.3.2.2	Pharmacy communication	Provide features to enable secure bidirectional communication of information electronically between practitioners and pharmacies.	Yes	Yes	Yes		Yes	Yes	Yes	No	No	No		Yes		Yes	No

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DC.3.2.3	Provider and patient or family communication	Trigger or respond to electronic communication (inbound and outbound) between providers and patients or patient representatives with pertinent actions in the care process.	Yes	Yes	No		Yes	No	Yes	No	Yes	Yes		Yes		Yes	Yes
DC.3.2.4	Patient, family and care giver education	Identify and make available electronically or in print any educational or support resources for patients, families, and caregivers that are most pertinent for a given health concern, condition, or diagnosis and which are appropriate for the person (s).	Yes	Yes	Yes		Yes	Yes	Yes			Yes	Yes	Yes		Yes	Yes
DC.3.2.5	Communication with medical devices	Support communication and presentation of data captured from medical devices.	Yes	Yes	No		No	Yes	Yes		Yes	Yes	Yes	No		Yes	Yes, HL7-based
S.1	Clinical Support															Yes	
S.1.1	Notifiable Registries	Enable the automated transfer of formatted demographic and clinical information to and from local disease specific registries (and other notifiable registries) for patient monitoring and subsequent epidemiological analysis.	No	Yes	Yes		No	Yes	Yes		Yes	Yes	Yes			Yes	No
S.1.2	Donor management support	Provide capability to capture or receive, and share needed information on potential organ and blood donors and recipients.	No	Yes	No		No	No	Yes		Yes	Yes				Yes	No

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S.1.3	Provider directory	Provide a current directory of provider information in accordance with relevant laws, regulations, and conventions.	No	Yes	No		Yes	Yes	Yes	Yes	Yes	Yes	Yes			Yes	No
S.1.3.1	Provider demographics	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security system.	No	Yes	No		Yes	No	Yes	Yes	No	Yes	Yes			Yes	No
S.1.3.2	Provider's location within facility	Provide provider location or contact information on a facility's premises.	Yes	Yes	No		Yes	Yes	Yes		No	Yes	Yes			Yes	No
S.1.3.3	Provider's on call location	Provide provider location or contact information when on call.	No	Yes	No		Yes	Yes	No		No	Yes	Yes			Yes	No
S.1.3.4	Provider's general location	Provide locations or contact information at which the provider practices, in order to direct patients or queries.	No	Yes	No		Yes	Yes	Yes		No	Yes	Yes			Yes	Yes
S.1.4	Patient directory	Provide a current directory of patient information in accordance with relevant privacy and other applicable laws, regulations, and conventions.	Yes	Yes	No		Yes	Yes	Yes	Yes	No	Yes	Yes			Yes	Yes
S.1.4.1	Patient demographics	Maintain, archive and update demographic information in accordance with realm-specific recordkeeping requirements.	Yes	Yes	Yes		Yes	Yes	Yes	Yes	No	Yes	Yes			Yes	Yes
S.1.4.2	Patient's location within a facility	Provide the patient's location information within a facility's premises.	Yes	Yes	N/A		Yes	Yes	Yes		No	Yes				Yes	No

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S.1.4.3	Patient's residence related to the provision and administration of services	Provide the patient's residence information solely for purposes related to the provision and administration of services to the patient, patient transport, and as required for public health reporting.	Yes	Yes	Yes		Yes	Yes	Yes		No	Yes	Yes			Yes	Yes
S.1.4.4	Optimize patient bed assignment	Enable interaction with a bed management system to ensure that the patient's bed assignments within the facility optimize care and minimize risks e.g. of exposure to contagious patients.	No	Yes	N/A		Yes	No	Yes		No	No				No	No
S.1.5	De-identified data request management	Provide patient data in a manner that meets local requirements for de-identification.	Yes	Yes	No		Yes	Yes	Yes			Yes	Yes			Yes	Yes
S.1.6	Scheduling	Provide the necessary data to a scheduling system for optimal efficiency in the scheduling of patient care, for either the patient or a resource/device.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes		Yes	Yes
S.1.7	Healthcare resource availability	Support the distribution of local healthcare resource information in times of local or national emergencies.	Yes	No	No		Yes	No	Yes			Yes				Yes	No
S.2	Measurement, Analysis, Research and Reports			Yes								Yes				Yes	Yes
S.2.1	Measurement, monitoring, and analysis	Support measurement and monitoring of care for relevant purposes.	Yes	Yes			Yes		Yes		Yes	Yes	Yes			Yes	Yes

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S.2.1.1	Outcome Measures	Support the capture and reporting of information for the analysis of outcomes of care provided to populations, in facilities, by providers, and in communities.	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
S.2.1.2	Performance and accountability measures	Support the capture and reporting of quality, performance, and accountability measures to which providers/facilities/delivery systems/communities are held accountable including measures related to process, outcomes, and/or costs of care – may be used in 'pay for performance' monitoring and adherence to best practice guidelines.	No	Yes	Yes	NO	Yes	Yes	Yes		Yes	Yes	Yes	Yes		Yes	Yes
S.2.2	Report generation	Provide report generation features for the generation of standard and ad hoc reports.	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
S.2.2.1	Health record output	Enable system user to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	Yes	Yes	No	No	Yes	Yes*	Yes	No	Yes	Yes	Yes	Yes		Yes	No
S.3	Administrative and Financial			Yes								Yes				Yes	
S.3.1	Encounter/Episode of care management	Manage and document the health care needed and delivered during an episode of care.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes

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S.3.1.1	Specialized views	Present specialized views based on the encounter-specific values, clinical protocols and business rules	No	Yes	No		Yes	Yes	Yes	Yes	Yes	Yes				Yes	No
S.3.1.2	Encounter specific functionality	Provide assistance in assembling appropriate data, supporting data collection and processing output from the encounter.	Yes	Yes	No		Yes	Yes	Yes	Yes	Yes	Yes	Yes			Yes	Yes
S.3.1.3	Automatic generation of administrative and financial data from clinical record	Derive administrative or financial data from the patient's clinical data and include this in administrative and financial reports.	No	Yes	No		Yes	Yes	Yes		Yes	Yes	Yes			Yes	Yes
S.3.1.4	Support remote healthcare services	Support remote health care services such as telehealth and remote device monitoring by integrating records and data collected by these means into the patient's EHR for care management, billing and public health reporting purposes.	Yes	No	No		No	Yes	Yes	No	Yes	Yes	Yes			Yes	No
S.3.2	Information access for supplemental use	Support extraction, transformation and linkage of information from structured data and unstructured text in the patient's health record for care management, financial, administrative, and public health purposes.	No	Yes	No		Yes	Yes	Yes		Yes	Yes	Yes			Yes	No
S.3.2.1	Rules-driven clinical coding assistance	Make available all pertinent patient information needed to support coding of diagnoses, procedures and outcomes.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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S.3.2.2	Rules-driven financial and administrative coding assistance	Provide financial and administrative coding assistance based on the structured data and unstructured text available in the encounter documentation.	Yes	Yes	Yes		No	Yes	Yes		Yes	Yes	Yes			Yes	No
S.3.2.3	Integrate cost/financial information	Enable the use of cost management information required to guide users and workflows.	No	Yes	No		No	No	Yes		No	Yes				Yes	No
S.3.3	Administrative transaction processing	Support the creation (including using external data sources, if necessary), electronic interchange, and processing of transactions listed below that may be necessary for encounter management during an episode of care.	No	Yes	Yes		Yes		Yes		Yes	Yes				Yes	No
S.3.3.1	Enrollment of patients	Support interactions with other systems, applications, and modules to enable enrollment of uninsured patients into subsidized and unsubsidized health plans, and enrollment of patients who are eligible on the basis of health and/of financial status in social service and other programs, including clinical trials.	No	Yes	No		No	Yes	Yes		No	Yes				Yes	No
S.3.3.2	Eligibility verification and determination of coverage	Support eligibility verification for health insurance and special programs, including verification of benefits and pre-determination of coverage.	No	Yes	No		No	No	Yes		No	Yes				Yes	No

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S.3.3.3	Service authorizations	Support the creation of requests, responses and appeals related to service authorization, including prior authorizations, referrals, and pre-certification.	No	Yes	No		No	No/Yes	Yes		Yes	Yes				Yes	No
S.3.3.4	Support of service requests and claims	Creation of health care attachments for submitting additional clinical information in support of service requests and claims.	Yes	Yes	Yes		Yes	Yes	Yes		Yes	No	Yes			Yes	No
S.3.3.5	Claims and encounter reports for reimbursement	Support the creation of claims and encounter reports for reimbursement	Yes	Yes	No		No	Yes	Yes		Yes	Yes	Yes			Yes	No
S.3.3.6	Health service reports at the conclusion of an episode of care.	Support the creation of health service reports at the conclusion of an episode of care. Support the creation of health service reports to authorized health entities, for example public health, such as notifiable condition reports, immunization, cancer registry and discharge data that a provider may be required to generate at the conclusion of an episode of care.	Yes	Yes	Yes		Yes	Yes	Yes		Yes	Yes	Yes			Yes	Yes
S.3.4	Manage Practitioner/Patient relationships	Identify relationships among providers treating a single patient, and provide the ability to manage patient lists assigned to a particular provider.	Yes	Yes	Yes		Yes	Yes	Yes		Yes	Yes				Yes	Yes

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S.3.5	Subject to Subject relationship	Capture relationships between patients and others and facilitate access on this basis (e.g. parent of a child) if appropriate.	Yes	Yes	No		Yes	Yes	Yes		Yes	Yes				Yes	Yes
S.3.5.1	Related by genealogy	Provide information of Related by genealogy (blood relatives)	No	Yes	No		Yes	Yes	Yes		Yes	Yes				No	No
S.3.5.2	Related by insurance	Provide information of Related by insurance (domestic partner, spouse, guarantor)	No	Yes	No		Yes	Yes	Yes		Yes	Yes				Yes	No
S.3.5.3	Related by living situation	Provide information of Related by living situation (in same household)	No	Yes	No		Yes	Yes	Yes		Yes	Yes				No	No
S.3.5.4	Related by other means	Provide information of Related by other means (e.g. epidemiologic exposure or other person authorized to see records – Living Will cases)	No	Yes	No		Yes	No	Yes		Yes	Yes				Yes	No
S.3.6	Acuity and Severity	Provide the data necessary for the capability to support and manage patient acuity/severity of illness/risk adjustment	No	Yes	No		Yes	Yes	Yes		Yes	Yes				Yes	No
S.3.7	Maintenance of supportive functions	Update EHR supportive content on an automated basis.	Yes	Yes			Yes	Yes	Yes		Yes	Yes				Yes	Yes
S.3.7.1	Clinical decision support system guidelines updates	Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material	No	Yes	No		No	Yes	Yes		No	Yes	Yes			Yes	No
S.3.7.2	Patient education material updates	Receive and validate formatted inbound communications to facilitate updating of patient education material	Yes	Yes	Yes		Yes	Yes	Yes		No	Yes	Yes			Yes	No

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S.3.7.3	Patient reminder information updates	Receive and validate formatted inbound communications to facilitate updating of patient reminder information from external sources such as Cancer or Immunization Registries	No	Yes	Yes		Yes	No	Yes		No	No	Yes			Yes	No
S.3.7.4	Public health related updates	Receive and validate formatted inbound communications to facilitate updating of public health reporting guidelines	No	Yes	Yes		Yes	No	Yes		No	No	Yes			Yes	No
I.1	Security	Secure the access to the EHR-S and EHR information. Prevent unauthorized use of data, data loss, tampering and destruction.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
I.1.1	Entity Authentication	Authenticate EHR-S users and/or entities before allowing access to an EHR-S. Manage the sets of access-control permissions granted within an EHR-S	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
I.1.2	Entity Authorization.	Manage the sets of access-control permissions granted to EHR-S users. An EHR-S grants authorizations to users, for roles, and within contexts. A combination of the authorization levels may be applied to control access to EHR-S functions or data.	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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I.1.3	Entity Access Control	Verify and enforce access control to EHR information and functions for end-users, applications, sites, etc., to prevent unauthorized use of a resource, including the prevention or use of a resource in an unauthorized manner.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
I.1.3.1	Patient Access Management	Enable a healthcare professional to manage a patient's access to the patient's personal health information. Patient access-management includes allowing access to patient/subject-of-care information and restricting access to information that is potentially harmful to the patient/subject.	HealthMatics	NO	No		Yes	Yes	Yes		Yes	Yes		Yes		Yes	Yes
I.1.4	Non-repudiation	Limit an EHR-S user's ability to deny (repudiate) an electronic data-exchange originated or authorized by that user.	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	?	Yes		Yes	Yes
I.1.5	Secure Data Exchange	Send and receive EHR data securely.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes
I.1.6	Secure Data Routing	Route electronically-exchanged EHR data only to/from known, registered, and authenticated destinations/sources (according to applicable healthcare-specific rules and relevant standards).	through MS	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes		Yes	Yes

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I.1.7	Document Attestation	Manage electronic attestation of documents including the retention of the signature of attestation (or certificate of authenticity) associated with an incoming or outgoing document.	No	Yes	Yes	No	Yes	Yes	Yes		Yes	Yes	Yes	No		Yes	Yes
I.1.8	Enforcement of Confidentiality	Enforce patient privacy rules as they apply to various parts of the EHR-S through the implementation of privacy mechanisms.	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes		Yes	Yes
I.2	Health record information and management	Manage EHR information across EHR-S applications by <ul style="list-style-type: none"> • Ensuring that clinical information is valid according to clinical rules; • Ensuring that clinical information is accurate and complete according to clinical rules; and • Tracking amendments to clinical documents 	No	Yes	No		Yes		Yes		Yes	Yes				Yes	Yes*

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I.2.1	Data Retention and Availability	Retain, ensure availability, and destroy health record information according to organizational standards. This includes: <ul style="list-style-type: none"> • Retaining all clinical documents for the time period designated by policy or legal requirement; • Retaining inbound documents as originally received (unaltered); • Ensuring availability of information for the legally proscribed period of time; • Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally proscribed retention period. 	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes		Yes		Yes	Yes
I.2.2	Audit trail	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date/time at which a record was created, modified, viewed, extracted, or deleted. Audit trails extend to information exchange. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for the EHR-S.	Yes	YES	Yes	Yes	Yes	Yes/No	Yes	Yes	Yes	Yes	No	Yes			Yes

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I.2.3	Synchronization	Maintain synchronization involving: <ul style="list-style-type: none"> • Interaction with entity directories; • Linkage of received data with existing entity records; • Location of each health record component; • Communication of changes between key systems. 	Yes	YES	No		Yes	No	Yes		No	Yes	?	Yes			Yes
I.2.4	Extraction of health record information	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions can be used to exchange data and provide reports for primary and ancillary purposes.	Yes	Yes	No	Yes	Yes	Yes	Yes		No	Yes	Yes	Yes			Yes

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I.3	Unique identity, registry, and directory services	Enable secure use of registry services and directories to uniquely identify, link and retrieve records and identify the location of subjects of care and providers for health care purposes; payers, health plans, sponsors, employers and public health agencies for administrative and financial purposes; health care resources and devices for resource management purposes.	Yes	Yes	Yes		Yes	Yes	Yes		No	Yes				Yes	No
I.3.1	Distributed registry access	Enable system communication with registry services through standardized interfaces and extend to services provided externally to the EHR-S.	No	Yes	Yes		Yes	Yes	Yes		No	Yes	Yes			Yes	No
I.4	Health Informatics and Terminology Standards	Ensure consistent terminologies, data correctness and interoperability by complying with standards for health care transactions, vocabularies, code sets, and artifacts such as templates, interface, decision support algorithms, and clinical document architecture.	Yes	Yes	No		Yes	Yes	Yes		No	Yes	Yes			Yes	Yes
I.4.1	Maintenance and versioning of health informatics and terminology standards.	Enable version control according to customized policies to ensure maintenance of utilized standards.	Yes	YES	No		Yes	Yes	Yes		Yes	No	?			Yes	Yes

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I.4.2	Mapping local terminology, codes, and formats	Map or translate local terminology, codes and/or formats to standard terminology, codes, and/or formats to comply with health informatics standards.	Yes	YES	Yes		No	No	Yes		No	No	Yes			Yes	No
I.5	Interoperability Standards	Provide automate health delivery processes and seamless exchange of key clinical and administrative information.	Yes	YES	Yes		Yes		Yes		Yes	Yes	Yes			Yes	Yes
I.5.1	Interchange Standards	Support the ability to operate seamlessly with complementary systems by adherence to key interoperability standards. Systems may refer to EHR systems, applications within an EHR-S, or other authorized entities that interact with an EHR-S.	Yes	YES	Yes	Yes	Yes	Yes	Yes		No	Yes	Yes	Yes		Yes	Yes
I.5.2	Application Integration Standards	Provide integration with complementary applications and infrastructure services (directory, vocabulary, etc.) using standard-based application programming interfaces (for example, CCOW).	Yes	Yes	No		No	Yes	Yes		No	Yes	Yes			Yes	No
I.5.3	Interchange Agreements	Support interaction with entity directories to determine the recipients' address profile and data exchange requirements and use these rules of interaction when exchanging information with partners.	Yes	Yes	No		Yes	Yes	Yes		No	Yes	No			No	No

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I.6	Business Rules Management	Manage the ability to create, update, delete (or disable) and version business rules including institutional preferences. Apply business rules from necessary points within the EHR-S to control system behavior. Audit changes made to business rules, and audit compliance to and overrides of applied business rules.	Yes	Yes	No		No	Yes	Yes		No	Yes				Yes	No
I.7	Workflow	Workflow management functions include both the management and set up of work queues, personnel, and system interfaces as well as the implementation functions that use workflow-related business rules to direct the flow of work assignments.	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes		Yes	Yes

Lumetra, in conjunction with CMS, has determined that for the purposes of DOQ – IT the functional requirements that will be used for information-gathering purposes are the HL7 System Functional Model and Standard – Draft Standard for Trial Use, March 2004. The HL7 System Functional Model and Standard – Draft Standard for Trial (DSTU) is used for the purpose described with the expressed written permission of the HL7 Board of Directors. As an American National Standards Institute (ANSI) Standards Development Organization (SDO) HL7 develops and publishes standards to facilitate healthcare system-to-system interoperability. Under special circumstances, ANSI allows SDOs to develop and publish a DSTU for the timely expression of requirements not covered by an existing standard. Once published, a DSTU is expected to receive comment which will result in either a revised DSTU or a final normative (non-draft) standard. A DSTU is valid for up to two years or up to six months after the publication of either a revised DSTU or a final normative standard.