

HEALTH RESOURCES AND SERVICES ADMINISTRATION
ELECTRONIC HEALTH RECORDS: SELECTION GUIDELINES FOR HEALTH CENTERS

Vendor Instructions for completing the Specifications Checklist

All vendors are required to complete all information requested in the “Vendor Profile” section.

When responding to the functional specification section, note that each functional statement’s priority is indicated in the “PRI” column which contains one of the following values:

H = Highly Desirable

D = Desirable

Where the function is provided by the system, place an “X” under one of the following columns:

“Yes, Included” = the function is available in the system and it is part of the basic system

“Yes, Additional Cost” = the function is available but it requires system customization at an additional cost

“No” = the function is not available

Use the column labeled **“Comments / Clarifications”** to include additional information you wish to include as part of your response. This column can also be used to indicate if a function is not currently available but will be available in a future release by indicating the version number and approximate month/year when the function will be available (e.g. V6.1/May 2008).

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VENDOR PROFILE

Company		Total current health care clients	
Address		Total current community health center (clients)	
Contact name and title		EHR Product name	
Contact telephone number		Largest installation (licenses)	
Contact fax number		Licensing terms	
Contact email address		<ul style="list-style-type: none"> • Maintenance included? 	
Company web site		<ul style="list-style-type: none"> • Training included? 	
Annual revenue		Frequency of upgrades	
Years in the community health center market		User Groups?	
Other		CCHIT Certified? Yes/No Date Certified:	

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
1 General					
1.1 The system supports both a total paperless function and a hybrid function, where the contents of the electronic record can be printed for inclusion in the paper chart	H				
1.2 The system interfaces with a variety of digital and analog dictation systems (state devices)	H				
1.3 The system date and time stamps all entries	H				
1.4 The system includes automatic translation of codes to data. For example:					
1.4.1 ICD-9-CM	H				
1.4.2 DSM-IV	D				
1.4.3 CDT	D				
1.4.4 CPT (4 and 5)	H				
1.4.5 ICD-10 (when available)	H				
1.4.6 SNOMED CT	H				
1.4.7 APC	H				
1.4.8 NDC	H				
1.5 The system includes support and updates for the above vocabularies	H				
1.6 The system supports user defined vocabularies, and allows for updates and enhancements of such vocabularies	D				
1.7 The system supports the HIPAA Standards for Electronic Transactions	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
1.8 The system supports the integration of third party coding programs	H				
1.9 The system includes extensive error checking of all user input data, including, but not limited to:					
1.9.1 ICD-9 (Check diagnosis against gender, age, other as necessary)	D				
1.9.2 ICD-9 procedure checking against diagnosis	D				
1.9.3 Extensive date checking for validity as well as ensuring a valid chronological order of events (dx before treatment, scheduling after birth, etc.)	D				
1.10 The system includes SNOMED CT as the integrated standard nomenclature of clinical terms.	H				
2 Demographics / Care Management					
2.1 The system supports the Continuity of Care Record, HITSP standard	H				
2.2 The system identifies and maintains a single patient record for each patient	H				
2.3 The system supports a user verifiable record merge function	D				
2.4 The system supports purging of incomplete or partial records (i.e. those created by autopopulation from the practice management system but for which no clinical data exists)	D				
2.5 The system captures and maintains demographic information. Where appropriate, the data should be clinically relevant, reportable, and traceable over time.	H				
2.6 The system creates and maintains patient-specific summary lists that are structured and coded where appropriate	D				
2.7 The system captures patient and family care preferences at the point of care	D				
2.8 The system has the capability of importing patient demographic data via HL7 interface from an existing Practice Management System, Patient Registration System, or any such system used for patient registration and/or scheduling. Of specific interest, are the following data:	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
2.8.1 Race	H				
2.8.2 Ethnic Group	H				
2.8.3 Housing Status	H				
2.8.4 Migrant Farm Working Status	H				
2.9 The system has the capability to import/create, review, update, and delete patient demographic information as well as other non-clinical information from the patient record in both PMS and EMR	H				
2.10 The system captures permanent patient address	H				
2.11 The system captures temporary patient addresses	H				
3 Patient History					
3.1 The system allows the capture, review, and management of medical procedural/OB/surgical, oral health, social, and family history, including the capture of pertinent positive and negative histories, and patient-reported or externally available patient clinical history (includes birth history, dietary (nutrition) history, immunization history, allergy and developmental history for pediatric patients/ behavioral history for adolescents)	H				
3.2 For each new patient, the system captures and stores risk factors. For example:					
3.2.1 History of STDs or STIs					
3.2.2 Sickle cell status					
3.2.3 TB Status					
3.2.4 Tobacco use and history including number of years and packs per day (PPD)	H				
3.2.5 Alcohol use, history	H				
3.2.6 Drug use, history	H				
3.2.7 Occupational Environment	H				
3.2.8 Living/Residential Environment	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
3.3 For each new patient, the system captures and stores the following social history elements:					
3.3.1 The system allows the tracking of domestic partners as well as married couples.	H				
3.3.2 Occupation	H				
3.3.3 Religious preference	H				
3.3.4 Socioeconomic status	H				
3.3.5 Native language	H				
3.3.6 Translator needed (Y/N)	H				
3.3.7 Education					
3.3.8 Housing Status					
3.3.9 Disabilities					
3.4 The system has the capability to import patient health history data, including obstetrical history data, from an existing system.	D				
3.5 The system documents hospitalization and emergency department data including:					
3.5.1 Admission and Discharge dates	H				
3.5.2 Chief complaint	D				
3.5.3 Admitting diagnosis / Other diagnoses	H				
3.5.4 Procedures performed	H				
3.5.5 Discharge summary	D				
3.5.6 Discharge disposition	H				
3.5.7 Emergency room visit and discharge date(s)					
3.6 The system documents all existing allergies and interactions, such as:					
3.6.1 Drug	H				

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3.6.2 Food	H				
3.6.3 Drug-food plus other (e.g bee sting, environmental allergies)	H				
3.7 The system captures history of received immunizations.	H				
3.8 The system has the capability of linking or grouping records of other family members on file.	D				
3.9 The system has the capability to capture and store genograms	D				
3.10 The system collects and stores family history, including, but not limited to:					
3.10.1.1 History of chronic diseases, including date of diagnosis	H				
3.10.1.2 Disease status	D				
3.10.1.3 Family member functional status	D				
3.10.1.4 If dead: date and cause of death	D				
3.11 The system presents a chronological, filterable, and comprehensive review of patient's EHR , which may be summarized, subject to privacy and confidentiality requirements	H				
3.12 The system captures and explicitly labels patient-provided and patient-entered clinical data and supports provider authentication for inclusion in patient history	D				
4 Current Health Data, Encounters, Health Risk Appraisal					

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
4.1 The system includes a combination of system default, provider customizable, and provider-defined and reusable templates for data capture.					
4.2 The system obtains test results from laboratory, radiology / imaging, or other equipment or technology related procedures and other clinical documents and notes via standard HL7 interface.	H				
4.3 The system has the capability to incorporate clinical documentation from external sources	H				
4.4 The system has the capability to capture and monitor patient health risk factors in a standard format.	H				
4.5 The system shall display encounter data using a problem-oriented format.	D				
4.6 The system supports online completion of the Health Survey (SF-36 – Health Status Measures) or similar measure for measuring health status and outcomes	D				
4.7 The system supports the capture, graphic display and plotting of “Growth Chart” information, adjustable by gestational age.	H				
4.8 The system supports the capture, graphic display and plotting of forms requiring graphic representation.	D				
4.9 The system has the capability of reproducing and displaying a variety of end user patient and treatment forms.	D				
4.10 The system has the capability to update other portions of the record with captured vital signs data. At minimum, the system collects:					
4.10.1 Height	H				
4.10.2 Weight	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
4.10.3 Height (Pediatrics) – Calculated percentile (English/metric)	H				
4.10.4 Weight (Pediatrics) – Calculated percentile (English/metric)	H				
4.10.5 Head circumference – Calculated percentile					
4.10.6 Pulse	H				
4.10.7 Respiratory rate	H				
4.10.8 Blood pressure (including multiples)	H				
4.10.9 Different position blood pressure	H				
4.10.10 Oximetry (with FiO2 identifier)	H				
4.10.11 Pain	H				
4.10.12 BMI (calculated)	H				
4.10.13 Visual Acuity (corrected / uncorrected)	H				
4.10.14 Audiology screening	H				
4.10.15 Other	H				
4.11 The system incorporates one or more accepted measure of functional level.	H				
4.12 The system supports at least one standard health status measure.	H				
4.13 The system has the capability to import/create, review, update, and amend health data (objective and subjective) regarding the patient’s current health status, including (as applicable):					
4.13.1 Chief complaint	H				
4.13.2 Onset of symptoms	H				
4.13.3 Injury mechanism	H				
4.13.4 Physical examination findings	H				
4.13.5 Psychological and social assessment findings	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
4.14 The system provides a flexible mechanism for retrieval of encounter information that can be organized in variety of 'views'. For example:					
4.14.1 By name (last, first; first, last; etc.)	H				
4.14.2 By date of birth	H				
4.14.3 Chronological by encounter date	H				
4.14.4 By diagnosis	H				
4.14.5 By diagnosis type	D				
4.14.6 By chart number	H				
4.14.7 By family group / linkage	D				
4.15 The system provides a flexible, user modifiable, search mechanism for retrieval of information captured during encounter documentation.	H				
4.16 The system provides a mechanism to capture, review, or amend history of current illness.	H				
4.17 The system ensures dynamic documentation during the encounter complying with all standard coding rules	D				
4.18 The system enables the origination, documentation, and tracking of referrals between care providers or healthcare organizations, including clinical and administrative details of the referral.	H				
4.19 The system has the capability to evaluate referrals within the context of the patient's clinical data	D				
4.20 The system captures the following referral information:					
4.20.1 Referral type (Reason for referral)	H				
4.20.2 Date	H				
4.20.3 Reason	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
4.20.4 Referring Provider	H				
4.20.5 Referred to Provider	H				
4.20.6 Payer	D				
4.21 The system tracks consultations and referrals	H				
4.22 The system has the capability of printing consultations / referrals forms	H				
5 Encounter – Progress Notes					
5.1 The system records progress notes utilizing a combination of system default, provider customizable, and provider-defined templates.	H				
5.2 The system has the capability to automatically update other sections of the record with data entered in the progress note	H				
5.3 The encounter - progress note template includes space for entering performed and planned procedures. It also includes:	H				
5.3.1 Performed/planned Laboratory procedures	H				
5.3.2 Diagnosis	H				
5.3.3 Goals (provider's and patient's) and follow-up plans	H				
5.3.4 Medications prescribed	H				
5.3.5 Non drug prescriptions (e.g. exercise, dietary recommendations/complementary and alternative therapies (including massage))					
5.3.6 Patient education materials	H				
5.3.7 Consultation/referrals	H				
5.3.8 Patient condition or status					

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
5.4 The system includes a progress note template that is problem oriented and can, at the user's option be linked to either a diagnosis or problem number.	D				
5.5 The system has the capability of retrieving encounters by a variety of user-defined parameters.	D				
5.6 The system enables standard phrases to be defined/contained in tables and used as pull down menus to reduce the key entry effort.	D				
5.7 The system enables progress notes to be sorted for viewing in chronological or reverse chronological order by encounter date in relation to the active care plan.	D				
5.8 The system applies security controls to progress notes to ensure that data cannot be deleted or altered except within the current session and by an authorized user.	H				
5.9 The system includes a medical terminology dictionary and a spell checker within the progress notes data entry module.	D				
5.10 The system supports the capability to automatically collect the data elements defined by the associated clinical practice guideline or order.	D				
6 Problem Lists					
6.1 The system creates and maintains patient-specific problem lists	H				
6.2 The system provides a problem status (active, inactive) for each shown problem.	H				
6.3 The system organizes applicable patient data into comprehensive problem summary lists.	H				
6.4 The system provides problem descriptions based on the SNOMED CT standard controlled vocabulary	H				

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6.5 The system allows clinicians to identify and record new patient problems as well as the current status of existing problems.	H				
6.6 The system expands the problem summary list on demand.	D				
6.7 The system updates the active problem list from relevant data in the progress note with appropriate end-user confirmation	D				
6.8 When capturing problem information, the system captures:					
6.8.1 Diagnosis / problem date(s)	H				
6.8.2 Severity of illness	H				
6.9 For each problem, the systems has the capability to create, review, or amend information regarding a change on the status of a problem to include, but not be limited to, the date the change was first noticed or diagnosed.	D				
6.10 The system has the capability of allowing the display of past interventions, hospitalizations, diagnostic procedures, and therapies for review at the option of the provider	H				
6.11 The system meets RBRVS/E&M documentation and coding guidelines	H				
7 Clinical Practice Guidelines (CPG)					
7.1 The system includes standard Clinical Practice Guidelines (CPG) for patient care as appropriate to support order entry and clinical documentation.	H				
7.2 The system has the capability of allowing initial authoring and revising of clinical practice guidelines	H				
7.3 The system allows linkages from the CPG to other system modules such as CDS.	D				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
7.4 The CPG module imports/creates the facility for rapid documentation of the patient's progress along the CPG phases.	D				
7.5 The format utilized by the guideline for documenting is intuitive, easy to use, and user customizable.	H				
7.6 The CPG module utilizes pull down menus and check boxes to speed up data entry.	H				
7.7 The system allows reporting and analysis of any / all components included in the CPG.	D				
7.8 Included in each CPG, the system has the capability to create, review, and update information about:	H				
7.8.1 The performance measures that will be used to monitor the attainment of objectives	H				
7.8.2 The quantitative and qualitative data to be collected	H				
7.8.3 Performance metrics: CPG shall allow for decision support based on standardized discrete data to be used to calculate clinical performance measures.	H				
7.8.4 Collection means and origin of data to be evaluated	H				
7.9 The system allows the provider or other authorized user to override any or all parts of the guideline.; the system is able to collect exceptions for NOT following the CPG	H				
8 Care Plans					
8.1 The system provides administrative tools for organizations to build care plans, guidelines, and protocols for use during patient care planning and care	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
8.2 The system identifies and presents the appropriate care plans, guidelines, and/or protocols for the management of specific conditions that are patient-specific	H				
8.3 The system has the capability to import/create, review, and amend information about the desired single or multi-disciplinary long / short term goals and objectives that will be accompanied by the care plan.	H				
8.4 The system has the capability to import/create, review, and amend information about the proposed set of single or multi-disciplinary care plan options that are based upon expected outcomes.	H				
8.5 The system generates and records patient-specific instructions related to pre- and post-procedural and post-discharge requirements	D				
8.6 The system has the capability to import/create, review, and amend information about:					
8.6.1 The provider's explanation and the patient's or patient representative's understanding of the recommended and/or alternative care plan options.	D				
8.6.2 The medical orders, which authorize the execution of the selected, care plan.	D				
8.6.3 The collection of specimens (body fluids, tissue, etc.) from the patient to be used for diagnostic or treatment purposes.	D				
8.6.4 The actions taken to safeguard the patient to avert the occurrence of morbidity, trauma, infection, or condition deterioration.	H				
9 Prevention					

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
9.1 The system has the capability to display prevention prompts on the summary display.	H				
9.2 The system allows interactive prevention status documentation. At minimum:					
9.2.1 Date addressed	H				
9.2.2 Result	H				
9.2.3 Reasons for not performed	H				
9.2.4 Where performed	H				
9.3 The system includes user-modifiable health maintenance templates.	H				
9.4 The system includes a patient tracking and reminder capability (patient follow-up).	H				
9.5 The system allows the graphing of pertinent data into flow sheets for presentation/display.	H				
9.6 The system includes the incorporation of immunization protocols:					
9.6.1 Universal child	H				
9.6.2 Universal adult	H				
9.6.3 Specific foreign travel					
10 Patient Education					
10.1 The system has the capability to create, review, update, or delete patient education materials	D				
10.2 The system has the capability of providing printed patient education materials in culturally appropriate languages on demand or automatically at the end of the encounter	D				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
10.3 The system includes or the capability to develop patient instructions in English and in the patient's native language for a broad range of treatments and services delivered by providers. Examples:					
10.3.1 Care of wound	H				
10.3.2 Exercise regimen	H				
10.3.3 Diet guidelines	H				
10.4 Administration and care of medications	H				
10.4.1 The system allows patient instructions to be selected from a pull down list.	D				
10.4.2 The system allows user modifications to instructions to suit individual patient needs without altering the original content.	D				
10.4.3 The system enables the linkage of patient instructions to care plans/care maps/ practice guidelines/orders, enabling automatic printing.	D				
10.5 The system allows patient instructions to be printed on demand independent of care plans/care maps/guidelines/orders	D				
10.6 The system includes the facility to create a directory of information for patient support groups and to include any applicable support group information in the instructions	D				
11 Alerts / Reminders					
11.1 The system includes user customizable alert screens / messages, enabling capture of alert details, including, but not being limited to:	H				
11.2 Text describing the alert	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
11.3 Date and time of the alert	H				
11.4 The system prints an alert on demand	H				
11.5 The system has the capability of forwarding the alert to a specific provider(s) or other authorized users via secure electronic mail or by other means of secure electronic communications	D				
11.6 The system tracks the user's response to an alert	D				
11.7 The system allows the user to document rationale for following/not following an alert	D				
12 Orders					
12.1 The system includes an electronic Order Entry module that has the capability to be interfaced with a number of key systems depending on the health center's existing and future systems as well as external linkages, through a standard, real time, HL7 two-way interface.	H				
12.2 The system captures and tracks orders based on input from specific care providers	H				
12.3 The system has the capability to submit diagnostic test orders based on input from specific care providers	H				
12.4 The system has the capability to print orders for manual transmission	H				
12.5 The system has the capability to fax orders.	H				
12.6 The system has the capability to require that all orders be digitally signed at the completion of each order.	H				
12.7 The system accepts orders from multiple locations.	H				

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12.8 The system has the capability to assign and display an order number for active, hold, and pending orders.	D				
12.9 During the order entry process, the system has the capability to require the user to acknowledge an error message prior to being allowed to continue with the data entry function.	H				
12.10 The system allows the user to accept, override, or cancel an order.	H				
12.11 The system requires the user to enter a justification for overriding, changing, or canceling an order prior to be allowed to continue	H				
12.12 The system includes the visual indication of orders in need of review.	H				
12.13 The system detects and displays duplicate orders issuing visual and auditory warnings, and allows the user to override the warning after entering a justification for the override.	H				
12.14 The system includes the capability to:					
12.14.1 Define order sets, based on provider input or system prompt, for each provider or service department.	D				
12.14.2 Contain all information specific to one order in one display screen.	H				
12.14.3 Include a pull-down list of all order departments to enable multiple orders	H				
12.14.4 Include a user-configurable / customizable pull-down list of tests and services from which to place one or more orders.	D				

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12.15 The system has the capability of displaying the most commonly used orders to assist in order placement.	D				
12.16 The system can display all order sets including components, by any of the following:	D				
12.16.1 By procedure	D				
12.16.2 By provider	D				
12.16.3 By diagnosis	D				
12.16.4 By date	D				
12.17 The system has the capability to specify/display exploding orders	H				
12.18 The system has the capability to enable selected orders to be recurring orders.	H				
12.19 The system includes an order inquiry mechanism to allow providers to inquire on the details of an order.	H				
12.20 The order inquiry function is accessible within the order entry flow before the session is terminated.	H				
12.21 An order, at the user's option, displays all the detail data associated with the order, including demographics, order parameters, electronic signatures, and order status	D				
12.22 The system displays order summaries on demand to allow the clinician to review/correct all orders prior to transmitting/printing the orders for processing by the receiving entity	H				
13 Results					

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13.1 The system has the capability to route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results	D				
13.2 The system accepts results via two way HL7 interface from all HL7 compliant / capable entities or through direct data entry. Specifically – Laboratory, Radiology, and Pharmacy information systems.	H				
13.3 The system includes an intuitive, user customizable results entry screen linked to orders	D				
13.4 The system displays results in a customizable, intuitive, and flexible format	H				
13.5 The system allows authorized users to copy selected results into a note	H				
13.6 When displaying results, the system, at a minimum, displays the patient name, date and time of order, date and time results were last updated, as well as any alerts identifying changes/amendments to the test or procedure, and test name	H				
13.7 The system has the capability to evaluate results and notify the provider within the context of the patient's clinical data	H				
13.8 The system uses visual cues to highlight abnormal results	H				
14 Medication and Immunization Management					
14.1 The system creates prescriptions or other medication orders with detail adequate for correct filling and administration. It provides information regarding compliance of medication orders with formularies	H				

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14.2 The system presents to appropriate clinicians the list of medications that are to be administered to a patient, under what circumstances, and captures administration details	D				
14.3 The system identifies drug interaction warnings at the point of medication ordering	H				
14.4 The system alerts providers to potential administration errors for both adults and pediatric patients, such as wrong patient, wrong drug, wrong dose, wrong route, and wrong time in support of medication administration or pharmacy dispense/supply management and workflow	D				
14.5 The medication module includes access to the National Drug Classification (NDC) database	H				
14.6 The system stores common prescriptions for quick entry.	H				
14.7 The systems supports multiple drug formularies and prescribing guidelines	H				
14.8 The system provides the capability to select both the patient and the drug to be prescribed from pull down menus.	H				
14.9 The system has the capability of creating and maintaining a current medication list for each patient and updates the progress note with prescription information as necessary	H				
14.10 At the provider's option the system has the capability of selecting drugs to be prescribed from the patient's medication list.	H				
14.11 The system allows the provider the ability to document the effectiveness or ineffectiveness of a medication.	H				
14.12 The system stores refill and repeat prescription information	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
14.13 The system allows storage of prescription data for retrieval by any or the following:					
14.13.1 Drug name	H				
14.13.2 Drug code number (NDC)	H				
14.13.3 Dosage prescribed	H				
14.13.4 Schedule, including formulary management	H				
14.13.5 Other user defined selection criteria	D				
14.14 The system provides the following drug/prescription order information:					
14.14.1 Drug contraindication	H				
14.14.2 Active problem interactions	H				
14.14.3 Check that appropriate studies are obtained	H				
14.15 The system provides extensive drug interaction information	H				
14.16 The system has the capability of alerting the provider where there is an illness or condition that may require careful consideration of the suggested therapy.	H				
14.17 The system creates and maintains patient-specific and adverse reaction lists and allows on demand or scheduled reporting from such lists	H				
14.18 The system includes clinician-modifiable therapeutic guidelines	H				
14.19 The system maintains a history of prescribed medicines.	H				
14.20 The system fully complies with existing regulations and restrictions applicable to the prescription of dangerous or regulated drugs.	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
14.21 The system provides the capability for electronic transfer of prescription information to a patient or organization selected pharmacy for dispensing.	H				
15 Confidentiality and Security					
15.1 The system supports biosensor technology for logon.	D				
15.2 Supports industry standard electronic signatures.	H				
15.3 The system controls access to and within the system at multiple levels (e.g. per user, per user role, per area, per section of the chart) through a consistent mechanism of identification and authentication of all users in accordance with the 'Role Based Access Control' (RBAC) standard.	H				
15.4 The system establishes patient/physician data element confidentiality.	D				
15.5 The system allows access to its modules regardless of location based on confidentiality and security procedures.	H				
15.6 The system incorporates audit trails of each access to specific data.	H				
15.7 The system incorporates an audit trail for all system transactions including look-ups of patient data.	H				
15.8 Provides automatic analysis of audit trails and unauthorized access attempts.	H				
15.9 Runs under B-2 or above rated operating system.	H				
16 Clinical Decision Support					
16.1 CDS should be built using National clinical data standards (LOINC, SNOMED, CPT, ICD9, etc)					
16.2 The system offers prompts to support the adherence to care plans, guidelines, and protocols at the point of information capture	D				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
16.3 The system identifies trends that may lead to significant problems and provide prompts for consideration	D				
16.4 The system supports the integration of patient and family preferences into clinical decision support at all appropriate opportunities	D				
16.5 The system includes access to medical research and literature databases such as MEDLINE, JAMA, GRATEFUL MED, and others.	H				
16.6 The system utilizes health data from all sections of the chart to provide decision support to providers.	H				
16.7 The system triggers alerts to providers when individual documented data indicates that critical interventions may be required.	H				
16.8 The system automatically triggers an alert upon documentation of a diagnoses or event required to be reportable to outside agencies including the Centers for Disease Control and Prevention (CDC) and State health and mental hygiene departments.	H				
16.9 The system automatically triggers an alert upon documentation of patient health data for a member of an existing medical registry or disease management program.	H				
16.10 The system's alert/reminder functions are driven by appropriate multi-disciplinary clinical guidelines.	H				
16.11 The system allows customized reports or studies to be performed utilizing individual and group health data from the electronic record.	D				
16.12 The system incorporates preventive medicine questionnaires to be completed by clinicians and if applicable, patients, during the encounter.	D				
17 Cost Measuring / Quality Assurance					
17.1 The system has built-in mechanism/access to other systems to capture cost information	D				

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17.2 The system generates an evaluation survey (scheduled and on-demand) that will record patient satisfaction	D				
17.3 The system supports real-time or retrospective trending, analysis, and reporting of clinical, operational, demographic, or other user-specified data	H				
17.4 The system produces workload measures	D				
17.5 The system produces reports of usage patterns	D				
17.6 The system has the capability to perform automatic cost analysis for courses of drug treatments	D				
17.7 The system provides the capability for authorized users to develop volume statistics reports on user determined data fields	D				
17.8 The system has the capability to produce population-based reports or studies based on flexible, end user modifiable criteria.	H				
17.9 The system has the capability of producing scheduled and on demand case mix reports.	D				
18 Chronic Disease Management					
18.1 The system provides support for the management of populations of patients that share diagnoses, problems, demographic characteristics, etc.	H				
18.2 The system supports disease management registries by:					
18.2.1 Allowing patient tracking and follow-up based on user defined diagnoses	H				
18.2.2 Integrating all patient information within the system	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
18.2.3 Providing a longitudinal view of the patient medical history	H				
18.2.4 Providing intuitive access to patient treatments and outcomes	H				
18.3 The system automatically identifies all high-risk patients and notifies clinical staff for preventive care.	H				
18.4 The system utilizes user authored and/or third party developed clinical guidelines for disease and registry management	H				
18.5 The system tracks / provides reminders and validates care process	H				
18.6 The system generates follow-up letters to physicians, consultants, external sources, and patients based on a variety of parameters such as date, time since last event, etc. for the purpose of collecting health data and functional status for the purpose of updating the patient's record	H				
18.7 At minimum, the system is able to generate a variety of reports based on performance measures identified by the Physician Consortium for Performance Improvement (AMA/Consortium), the Centers for Medicare & Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA) for chronic diseases including diabetes, coronary artery disease, heart failure, behavioral health, hypertension, osteoarthritis, and asthma, as well as for prenatal care and several preventive services including immunizations, lead testing, tobacco use cessation, and problem drinking. Information on these measures can be found at: http://www.ama-assn.org/ama/pub/category/12779.html . The system follows measures approved by NQF (national quality form) and prompted by the AQA (ambulatory quality alliance) as well as those identified by the BPHC's HDC	H				
18.8 The system links Disease Management functions to all other sections of the EHR	D				
19 Consents, Authorizations, and Directives					

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19.1 The system has the capability to create, maintain, and verify patient treatment decisions in the form of consents and authorizations when required	D				
19.2 The systems captures, maintains, and provides access to patient advance directives	D				
20 Technical Underpinnings					
20.1 The system auto-populates user defined data fields with patient demographics at the time of order or request	H				
20.2 The system is scalable	H				
20.3 The system incorporates a consistent user interface for data entry independent of the platform	H				
20.4 The system supports a variety of input modalities such as voice recognition, touch screen, light pen, mouse, keyboard, etc.	D				
20.5 The system will be accessible and available to all authorized users 99.5% of the time	H				
20.6 The system supports document scanning	H				
20.7 The system's response time is 2 seconds or less 90% of the time	H				
20.8 The system supports a sub second response time 80% of the time	H				
20.9 The system supports remote system monitoring technology	D				
20.10 The system incorporates extensive, secure telecommunications capabilities that link staff and clinicians from remote locations to the central site	H				
20.11 The system supports an industry standard locking mechanism to prevent unauthorized updates	H				

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20.12 The system supports and implements system redundancy / fault tolerance for 100% availability	H				
20.13 The system logs all transactions processing and archiving	H				
20.14 The system alerts simultaneous users of each other's presence in the same record	H				
21 Clinical IT Data Dictionary					
21.1 The system is structured to support skeleton-to-robust EHR.	H				
21.2 Provides attributes for each data element; supports all data types.	H				
21.3 Supports static/dynamic data element relationship.	H				
22 Input Mechanisms					
22.1 The system supports a full range of input technologies.	H				
22.2 Input protocol is easy/fast; intuitive input interface.	H				
22.3 The system capitalizes on the "repetitive nature of medicine".	H				
22.4 The system has the ability to allow inclusion of free text as well as the capture of discrete data.	H				
23 Ergonomic Presentation					
23.1 The system places emphasis on user friendliness	H				
23.2 The system incorporates a consistent presentation of information across the entire system	H				

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Specifications	PRI	Yes, Included	Yes, Additional Cost	No	Comments / Clarifications
23.3 The system incorporates visual cues	H				
23.4 The system provides consistent formatting to aid users in finding information	H				
24 Billing					
24.1 The system provides support to the provider on E & M coding based on documentation from the current visit.	H				
24.2 The system provides a bidirectional interface with practice management systems	H				