



Ambulatory Certification Criteria
2008 Final Criteria
 May 13, 2008

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2008 Criteria #	Source WG	Certification Track	Category	Category Description	Criteria	Compliance			Discussion / Comments	Source or References	Test Script Reference	Internal WG #
						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
AM 01.01	AM	AM	Identify and maintain a patient record	Key identifying information is stored and linked to the patient record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the patient.	The system shall create a single patient record for each patient.	P				DC.1.1.1	1.02	
AM 01.02	AM	AM	Identify and maintain a patient record	Key identifying information is stored and linked to the patient record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the patient.	The system shall associate (store and link) key identifier information (e.g., system ID, medical record number) with each patient record.	P			Key identifier information must be unique to the patient record but may take any system defined internal or external form.	DC.1.1.1	1.02	
AM 01.03	AM	AM	Identify and maintain a patient record	Key identifying information is stored and linked to the patient record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the patient.	The system shall provide the ability to store more than one identifier for each patient record.	P			For interoperability, practices need to be able to store additional patient identifiers. Examples include an ID generated by an Enterprise Master Patient Index, a health plan or insurance subscriber ID, regional and/or national patient identifiers if/when such become available.	DC.1.1.1	1.03	
AM 01.04	AM	AM	Identify and maintain a patient record	Key identifying information is stored and linked to the patient record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the patient.	The system shall provide a field which will identify patients as being exempt from reporting functions.	P			Examples may include patients who are deceased, transferred, moved, seen as consults only. Being exempt from reporting is not the same as de-identifying a patient who will be included in reports. De-identifying patients for reporting is addressed in the "Health record output" functionality.	DC.1.1.1	4.73	AF 01.06
AM 01.05	AM	AM	Identify and maintain a patient record	Key identifying information is stored and linked to the patient record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the patient.	The system shall provide the ability to merge patient information from two patient records into a single patient record.			N	If a duplicate chart is created, information could be merged into one chart.	DC.1.1.1		AF 01.07

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AM 02.01	AM	AM	Manage patient demographics	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	The system shall provide the ability to include demographic information in reports.	P			This includes using demographics to generate reports and also allows demographics to be gathered into a report. See also "Report generation" functionality.	DC.1.1.2	1.03	AF 02.02
AM 02.02	AM	AM	Manage patient demographics	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	The system shall provide the ability to maintain and make available historic information for demographic data including prior names, addresses, phone numbers and email addresses.	P			Providers need this for look up and contact purposes, e.g., when attempting to locate a patient or family member for clinical communications.	DC.1.1.2	1.06	AF 02.03
AM 02.03	AM	AM	Manage patient demographics	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	The system shall provide the ability to maintain at least two names or aliases for the same patient.			N				AF 02.03.01
AM 02.04	AM	AM	Manage patient demographics	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	The system shall provide the ability to modify demographic information about the patient.	P				DC.1.1.2	1.05	
AM 02.05	AM	AM	Manage patient demographics	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	The system shall store demographic information in the patient medical record in separate discrete data fields, such that data extraction tools can retrieve these data.	P				DC.1.1.2	1.05	
FN 01.01	FN	FN	01. Manage Patient Demographics	Capture and maintain demographic information. Where appropriate, the data should be clinically relevant and reportable.	The system shall provide the ability to access demographic information such as name, date of birth and gender needed for patient care functions.			N	Examples of a minimum set of demographic data elements include: name, address, phone number and date of birth. It is assumed that all demographic fields necessary to meet legislative, regulatory, research and public health requirements will be included.		1.03	FN.1

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FN 01.02	FN	FN	01. Manage Patient Demographics	Capture and maintain demographic information. Where appropriate, the data should be clinically relevant and reportable.	The system shall capture and maintain demographic information as discrete data elements as part of the patient record.	N			Examples of a minimum set of demographic data elements include: name, address, phone number and date of birth. It is assumed that all demographic fields necessary to meet legislative, regulatory, research and public health requirements will be included.		1.02	FN.2
FN 02.01	FN	FN	02. Identify and Maintain a Patient Record	Identify and maintain a single patient record for each patient	The system shall provide the ability to query for a patient by more than one form of identification.	P					1.03	FN.3
FN 03.01	FN	FN	03. 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.	The system shall provide the ability to capture and maintain, as discrete data elements, the identity of all providers associated with a specific patient encounter.	M			A provider is defined as anyone delivering clinical care such as physicians, PAs, CNPs and Nurses; the provider is the person who completes the note.	S.3.4	1.66	FN.4
FN 03.02	FN	FN	03. 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.	The system shall provide the ability to capture and maintain, as discrete data elements, the principal provider responsible for the care of an individual patient.	M				S.3.4	4.05	FN.5
AM 03.01	AM	AM	Manage problem list	Create and maintain patient specific problem lists.	The system shall provide the ability to display all current problems associated with a patient.	P			We assume current and active to mean the same thing. This item will be removed in 2009 when the corresponding Foundation criterion is tested.	DC.1.4.3	2.16, 4.11, 4.44	
AM 03.02	AM	AM	Manage problem list	Create and maintain patient specific problem lists.	The system shall provide the ability to maintain a history of all problems associated with a patient.	P			This means both current and inactive and/or resolved problems. These may be viewed on separate screens or the same screen. Ideally each discrete problem would be listed once. This item will be removed in 2009 when the corresponding Foundation criterion is tested.	DC.1.4.3	2.16, 4.11, 4.40, 4.44	
AM 03.03	AM	AM	Manage problem list	Create and maintain patient specific problem lists.	The system shall provide the ability to maintain the onset date of the problem.	P			It is a vendor design decision whether to require complete date or free text of approximate date.	DC.1.4.3	2.16	
AM 03.04	AM	AM	Manage problem list	Create and maintain patient specific problem lists.	The system shall provide the ability to maintain the resolution date of the problem.		N					AF 03.03.01
AM 03.05	AM	AM	Manage problem list	Create and maintain patient specific problem lists.	The system shall provide the ability to record the chronicity (chronic, acute/self-limiting, etc.) of a problem.	P				DC.1.4.3	4.18	AF 03.04
AM 03.06	AM	AM	Manage problem list	Create and maintain patient specific problem lists.	The system shall provide the ability to record the user ID and date of all updates to the problem list.	P			This item will be removed in 2009 when the corresponding Foundation criterion is tested.	DC.1.4.3	4.11, 4.40, 4.44	AF 03.05
AM 03.07	AM	AM	Manage problem list	Create and maintain patient specific problem lists.	The system shall provide the ability to associate orders, medications, and notes with one or more problems.	M			Association can be made in structured data or in non-structured data.	DC.1.4.3	4.28, 4.42	AF 03.06
AM 03.08	AM	AM	Manage problem list	Create and maintain patient specific problem lists.	The system shall provide the ability to associate orders, medications and notes with one or more codified problems.		N					AF 03.07

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AM 03.09	AM	AM	Manage problem list	Create and maintain patient specific problem lists.	The system shall provide the ability to maintain a coded list of problems.	P			For example: ICD-9 CM, ICD-10 CM, SNOMED-CT, DSM-IV. The Functionality WG will not specify which code set(s) are to be employed.	DC.1.4.3	2.15, 4.11, 4.44	AF 03.08
AM 03.10	AM	AM	Manage problem list	Create and maintain patient specific problem lists.	The system shall provide the ability to display inactive and/or resolved problems.	P					4.11, 4.44	AF 03.09
AM 03.11	AM	AM	Manage problem list	Create and maintain patient specific problem lists.	The system shall provide the ability to separately display active problems from inactive/resolved problems.	P			This item will be removed in 2009 when the corresponding Foundation criterion is tested.		4.12	AF 03.10
FN 04.01	FN	FN	04. Manage Problem Lists	Create and maintain patient-specific problem lists.	The system shall provide the ability to capture, maintain and display, as discrete data, free text comments associated with the problem / diagnosis.			N				FN.6
FN 04.02	FN	FN	04. Manage Problem Lists	Create and maintain patient-specific problem lists.	The system shall provide the ability to capture, maintain and display, as discrete data elements, all current problems associated with a patient.			N				FN.60
FN 04.03	FN	FN	04. Manage Problem Lists	Create and maintain patient-specific problem lists.	The system shall provide the ability to capture, maintain and display, as discrete data elements, historical problems associated with a patient.			N				FN.61
FN 04.04	FN	FN	04. Manage Problem Lists	Create and maintain patient-specific problem lists.	The system shall provide the ability to print a problem/diagnosis list.			N	A screen print is not the intention of this criterion.			FN.62
FN 04.05	FN	FN	04. Manage Problem Lists	Create and maintain patient-specific problem lists.	The system shall provide the ability to capture and maintain, as discrete data elements, the specific problem / diagnosis, user, date and time of all updates to the problem list.			N		DC.1.4.3		FN.7
FN 04.06	FN	FN	04. Manage Problem Lists	Create and maintain patient-specific problem lists.	The system shall provide the ability to separately display active problems from inactive/resolved problems.			N				FN.8
AM 04.01	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall provide the ability for the user to expressly indicate that the medication list has been reviewed; this must be stored as structured data. The system must capture and display the ID of the user conducting the review, and the date of the review.			N				AF 04.01.01
AM 04.02	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall provide the ability to record the prescribing of medications including the identity of the prescriber.	P				DC.1.4.2	1.51	
AM 04.03	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall provide the ability to maintain medication ordering dates.	P				DC.1.4.2	1.49	
AM 04.04	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall provide the ability to maintain other dates associated with medications including start, modify, renewal and end dates as applicable.	P				DC.1.4.2	1.49, 1.55, 4.19, 4.20	
AM 04.05	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall provide the ability to display medication history for the patient.	P			For clarification, medication history includes all medications prescribed since the EMR was established.	DC.1.4.2	4.43	

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AM 04.06	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall provide the ability to capture medications entered by authorized users other than the prescriber.	P			It is important to have all current medications in the system for drug interaction checking. This in the future would include the incorporation of medication history obtained from outside electronic interfaces from insurers, PBMs, etc. "User" means medical and non-medical staff who are authorized by policy to enter prescriptions or other documentation.	DC.1.4.2	4.38, 4.43	
AM 04.07	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall store medication information in discrete data fields. At a minimum, there must be one field for each of the following: - medication name, form and strength; - dispense quantity; - refills; and - sig.		N			DC.1.4.2		AF 04.10
AM 04.08	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall include standard medication codes associated with each medication in the list for medications in the vendor-provided medication database.			N	This criterion is intended to refer to nationally accepted standards for encoding medications when those become available and the specific standard would be stipulated in an interoperability criterion.	DC.1.4.2		AF 04.13
AM 04.09	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall provide the ability to enter uncoded or free text medications when medications are not on the vendor-provided medication database or information is insufficient to completely identify the medication.	P			Medications that are not on the vendor-provided medication database or not enough information is available to completely identify the medication. This could be either uncoded (Synthroid unknown dose) or free text (blue hypertension pill).		4.27	AF 04.14
AM 04.10	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall provide the ability to enter or further specify in a discrete field that the patient takes no medications.	P					4.90	AF 04.16
AM 04.11	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall provide the ability to record the date of changes made to a patient's medication list and the identity of the user who made the changes.	P			This information may appear as an optional view rather than a required view on the main screen. Need to capture the identity of the user and the date of changes made. Changes are to be recorded at the level of the individual medication.		4.33	AF 04.17
AM 04.12	AM	AM	Manage medication list	Create and maintain patient specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	The system shall provide the ability to automatically exclude from the display of current medications a prescription whose duration has been exceeded or end date has passed.			N				AF 04.18
FN 06.01	FN	FN	06. Manage Medication List	Create and maintain patient-specific medication lists.	The system shall provide the ability to update and display a patient-specific medication list based on current medication orders or prescriptions.	P				DC.1.4.2	1.59, 4.19, 4.20, 4.43, 4.66	FN.20
FN 06.02	FN	FN	06. Manage Medication List	Create and maintain patient-specific medication lists.	The system shall provide the ability to display a view that includes only current medications.	N					4.21, 4.38	FN.21

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FN 06.03	FN	FN	06. Manage Medication List	Create and maintain patient-specific medication lists.	The system shall provide the ability to exclude a medication from the current medication list (e.g. marked inactive, erroneous, completed, discontinued) and document reason for such action.	N					4.32, 4.43	FN.22
FN 06.04	FN	FN	06. Manage Medication List	Create and maintain patient-specific medication lists.	The system shall provide the ability to print a current medication list.	P				DC.1.4.2	1.61	FN.23
FN 06.05	FN	FN	06. Manage Medication List	Create and maintain patient-specific medication lists.	The system shall provide the ability to display that the patient takes no medications.	N					4.90	FN.24
FN 06.06	FN	FN	06. Manage Medication List	Create and maintain patient-specific medication lists.	The system shall provide the ability to capture and maintain, as discrete data elements, all current medications including over-the-counter and complementary medications such as vitamins, herbs and supplements.	M				DC.1.4.2	4.19, 4.20, 4.34, 4.38, 4.43	FN.25
AM 05.01	AM	AM	Manage allergy and adverse reaction list	Create and maintain patient specific allergy and adverse reaction lists.	The system shall provide the ability to capture and store lists of medications and other agents to which the patient has had an allergic or other adverse reaction in a standard coded form.			N	Pending standard codes for allergens.			AF 05.01.01
AM 05.02	AM	AM	Manage allergy and adverse reaction list	Create and maintain patient specific allergy and adverse reaction lists.	The system shall provide the ability to record the inactivation of items from the allergy list.	P			Necessary for medico-legal purposes. This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely.	DC.1.4.1	1.17	AF 05.05
AM 05.03	AM	AM	Manage allergy and adverse reaction list	Create and maintain patient specific allergy and adverse reaction lists.	The system shall provide the ability to display information which has been inactivated or removed from the allergy and adverse reaction list.			N	Could include changing the type of reaction for a particular allergy.	DC.1.4.1		AF 05.09
AM 05.04	AM	AM	Manage allergy and adverse reaction list	Create and maintain patient specific allergy and adverse reaction lists.	The system shall provide the ability to distinguish between an allergy and an intolerance as discrete data.			N				AF 05.10
FN 05.01	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability to modify or inactivate an item on the allergy and adverse reaction list.	P			This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active, as opposed to deleting the information from the database entirely.		1.17	FN.11
FN 05.02	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability to capture and maintain, as discrete data, the reason for inactivating or removing an item from the allergy and adverse reaction list.			N	This could include removal, marking as erroneous, or marking as inactive. "Remove" in this context implies specifying that an allergy or allergen specification is no longer valid or active, as opposed to deleting the information from the database entirely.	DC.1.4.1		FN.12
FN 05.03	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability to specify the type of allergic or adverse reaction.	P				DC.1.4.1	1.20	FN.13

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FN 05.04	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability to specify the type of allergic or adverse reaction in a discrete data field.		N					FN.14
FN 05.05	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability to capture and maintain, as discrete data, the identity of the user who added, modified, inactivated or removed items from the allergy and adverse reaction list, including attributes of the changed items. The user ID and date/time stamp shall be recorded.	M			Attributes include the name of the allergen and the action (added, modified, inactivated or removed).		1.18	FN.15
FN 05.06	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability for a user to explicitly document that the allergy list was reviewed. The user ID and date/time stamp shall be recorded when the allergies reviewed option is selected.	N					1.26, 1.27	FN.16
FN 05.07	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability for a user to explicitly capture and maintain, as discrete data, that the allergy list was reviewed. The user ID and date/time stamp shall be recorded when the allergies reviewed option is selected.		N					FN.17
FN 05.08	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability to explicitly indicate that a patient has no known drug allergies or adverse reactions.	P					2.06	FN.18
FN 05.09	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability to explicitly indicate in a discrete field that a patient has no known drug allergies or adverse reactions.		N					FN.19
FN 05.10	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability to capture the source of the allergy information.		N		Documenting source in a free-text field associated with the allergy record is acceptable; in future years this will be captured in discrete data.			FN.66
FN 05.11	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability to capture the source of the allergy information in a discrete field.			N	This criterion will replace FN 05.10 when it comes into effect in 2010.			FN.66.01
FN 05.12	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability to display the allergy list, including date of entry.		N					FN.67
FN 05.13	FN	FN	05. Manage Allergy Intolerance and Adverse Reaction List	Create and maintain patient-specific allergy, intolerance and adverse reaction lists.	The system shall provide the ability to capture, maintain and display, as discrete data, lists of medications and other agents to which the patient has had an allergic or other adverse reaction.	P					1.16, 1.19	FN.9

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AM 06.01	AM	AM	Manage patient history	Capture, review, and manage medical, procedural/surgical, social and family history including the capture of pertinent positive and negative histories, patient reported or externally available patient clinical history.	The system shall provide the ability to capture, store, display, and manage patient history.	P			Examples include past medical/surgical problems, diagnoses, procedures, family history and social history.	DC.1.2	2.11	
AM 06.02	AM	AM	Manage patient history	Capture, review, and manage medical, procedural/surgical, social and family history including the capture of pertinent positive and negative histories, patient reported or externally available patient clinical history.	The system shall provide the ability to capture structured data in the patient history.	P			This function demonstrates the ability of a system to capture structured data but does not define the required elements of the patient history that shall be structured. Discrete data elements allow for searching and/or reporting by the EHR, and for this criterion the data could be free text or codified. Future functions would define the required patient history elements that shall be captured discretely as structured data, and where appropriate codified terminologies will be used.	DC.1.2	2.12	
AM 06.03	AM	AM	Manage patient history	Capture, review, and manage medical, procedural/surgical, social and family history including the capture of pertinent positive and negative histories, patient reported or externally available patient clinical history.	The system shall provide the ability to update a patient history by modifying, adding or removing items from the patient history as appropriate.	M			Requirement not predicated on the capture of structured data.	DC.1.2	2.11	
AM 06.04	AM	AM	Manage patient history	Capture, review, and manage medical, procedural/surgical, social and family history including the capture of pertinent positive and negative histories, patient reported or externally available patient clinical history.	The system shall provide the ability to capture patient history as both a presence and absence of conditions, i.e., the specification of the absence of a personal or family history of a specific diagnosis, procedure or health risk behavior.	P			Requirement not predicated on the capture of structured data.	DC.1.2	2.12	
AM 06.05	AM	AM	Manage patient history	Capture, review, and manage medical, procedural/surgical, social and family history including the capture of pertinent positive and negative histories, patient reported or externally available patient clinical history.	The system shall provide the ability to capture history collected from outside sources.	M			This could include data from a personal health record, online patient histories, and information from pharmacy benefit management organizations. Please see interoperability criteria IA-19, IA 34 and IA-35 for specific requirements for electronic importation.	DC.1.2	2.07	
AM 06.06	AM	AM	Manage patient history	Capture, review, and manage medical, procedural/surgical, social and family history including the capture of pertinent positive and negative histories, patient reported or externally available patient clinical history.	The system shall provide the ability to capture patient history in a standard coded form.	N			Not all data elements may currently be represented in existing standard coding schemes. An example would be diagnostic and procedural history using ICD-9, CPT, or SNOMED codes.	DC.1.2	2.13	

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AM 06.07	AM	AM	Manage patient history	Capture, review, and manage medical, procedural/surgical, social and family history including the capture of pertinent positive and negative histories, patient reported or externally available patient clinical history.	The system shall be capable of documenting current and past tobacco use in a quantitative fashion.		N		Any quantitative measure of amount of consumption, time of start, time of stop, or total duration would be acceptable.			
AM 06.08			Manage patient history	Capture, review, and manage medical, procedural/surgical, social and family history including the capture of pertinent positive and negative histories, patient reported or externally available patient clinical history.	The system shall be capable of documenting that tobacco cessation counseling was provided, including a date stamp.		N					
AM 07.01	AM	AM	Summarize health record		The system shall provide the ability to create and display a summary list for each patient that includes, at a minimum, the active problem list, current medication list, medication allergies and adverse reactions	P			Health record summary is at the patient level as opposed to at the level of an individual visit or episode of care.	DC.1.1.4	4.30	
AM 08.01	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to create clinical documentation or notes (henceforth "documentation").	P				DC.1.9.1	2.08, 2.10, 4.19, 4.57, 4.63, 4.63 a	
AM 08.02	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to display documentation.	P				DC.1.9.1	2.08, 2.10, 4.19, 4.57, 4.63, 4.63 a	
AM 08.03	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to save a note in progress prior to finalizing the note.	P				DC.1.9.1	4.39	
AM 08.04	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to finalize a note, i.e., change the status of the note from in progress to complete so that any subsequent changes are recorded as such.	P			Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or finalize a clinical note. The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.	DC.1.9.1	1.65, 4.45	

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						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
AM 08.05	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to record the identity of the user finalizing each note and the date and time of finalization.	P			Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or finalize a clinical note. The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.	DC.1.9.1	1.60, 1.65, 4.45	
AM 08.06	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to cosign a note and record the date and time of signature.	P			The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards. ASTM has developed "2003 Updated ASTM Standard Guide for Electronic Authentication of Health Care Information" to address some of these issues.		1.65	

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AM 08.07	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to addend and/or correct notes that have been finalized.	P			The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.	DC.1.9.1	4.55	
AM 08.08	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to identify the full content of a modified note, both the original content and the content resulting after any changes, corrections, clarifications, addenda, etc. to a finalized note.		N		This may be in the GUI or in the audit trail. It is adequate to be able to access pre- and post-modification versions of a note; i.e. it is not necessary for the system to have a single display that shows what modifications were made.			AF 08.07.01
AM 08.09	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to record and display the identity of the user who addended or corrected a note and the date and time of the change.		M		Necessary for medico-legal purposes. The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.	DC.1.9.1	4.55	AF 08.08
AM 08.10	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to enter free text notes.	P				DC.1.9.1	2.31	AF 08.09
AM 08.11	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to filter, search or order notes by the provider who finalized the note.	P				DC.1.9.1	4.68	AF 08.10
AM 08.12	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to filter, search or order notes by associated diagnosis within a patient record.	P			This is intended to be the coded diagnosis and not free text in the body of a note.	DC.1.9.1	4.23, 4.31	AF 08.11

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AM 08.13	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to capture patient vital signs, including blood pressure, heart rate, respiratory rate, height, and weight, as discrete data.	P			It is understood that vendors should support conversion to numeric values that can be graphed. Coding in ICD-9 CM, ICD 10 CM, SNOMED, UMLS, etc., would enhance interoperability and for public health surveillance or clinical research.	DC.1.9.1	1.21, 2.02	AF 08.12
AM 08.14	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to capture and display temperature, weight and height in both metric and English units		N					AF 08.12.01
AM 08.15	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall be capable of indicating to the user when a vital sign measurement falls outside a preset normal range as set by authorized users.		N		Normal range shall be set at system level as opposed to individual patient level.			AF 08.12.02
AM 08.16	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to capture other clinical data elements as discrete data.		N		For example peak expiratory flow rate, size of lesions, severity of pain, etc.	DC.1.9.1	1.22	AF 08.13
AM 08.17	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to display other discrete numeric clinical data elements, such as peak expiratory flow rate or pain scores, in tabular and graphical form.		N		Listed items are examples only.			AF 08.13.01
AM 08.18	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to capture and store discrete data regarding symptoms, signs and clinical history, from a clinical encounter and to associate that data with codes from standardized nomenclatures.		N		Examples include but are not limited to SNOMED-CT, ICD-9 CM, ICD-10 CM, DSM-IV, CPT-4, MEDCIN, and LOINC. This would allow symptoms to be associated with SNOMED terms, labs with LOINC codes, etc. The code associated with a note would remain static even if the code is updated in the future.	DC.1.9.1		AF 08.14
AM 08.19	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide templates for inputting data in a structured format as part of clinical documentation.		M			DC.1.9.1	1.21, 2.08	AF 08.15
AM 08.20	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to customize clinical templates.		P			DC.1.9.1	2.09	AF 08.16
AM 08.21	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall be capable of recording comments by the patient or the patient's representative regarding the accuracy or veracity of information in the patient record (henceforth 'patient annotations').		M		For the current year it is sufficient for these to be recorded as either free-text notes or scanned paper documents. It is not required that the system facilitate direct entry into the system by the patient or patient's representative.		1.29	AF 08.18
AM 08.22	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall display patient annotations in a manner which distinguishes them from other content in the system.		N		A patient annotation in free-text or scanned document form as described in AF 8.18, when displayed, should indicate that it comes from a patient. This could be a text label on the screen or part of the free-text note itself. It is not necessary to make patient annotations visible from any and all sections of the patient record.		1.30	AF 08.19

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AM 08.23	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to identify and maintain patient or patient proxy completed clinical information.			N	Once verified by a physician and shared with other parts of the chart, the shared data does not need to be identified as patient completed in all sections where data may be shared, but the original patient completed information shall be maintained.			AF 08.20
AM 08.24	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to graph height and weight over time.	P					1.23	AF 08.21
AM 08.25	AM	AM	Manage clinical documents and notes	Create, correct, authenticate and close, as needed, transcribed or directly entered clinical information.	The system shall provide the ability to calculate and graph body mass index (BMI) over time.			N				AF 08.22
AM 09.01	AM	AM	Capture external clinical documents	Incorporate clinical documentation from external sources	The system shall provide the ability to capture and store external documents.			M	Scanned documents are sufficient; structured data will be expected in the future. This covers all types of documents received by the practice that would typically be incorporated into a medical record, including but not limited to faxes, referral authorizations, consultant reports, and patient correspondence of a clinical nature.	DC.1.1.3.1	4.51	
AM 09.02	AM	AM	Capture external clinical documents	Incorporate clinical documentation from external sources	The system shall provide the ability to receive, store in the patient's record, and display discrete lab results received through an electronic interface.	P			This may be an external source such as a commercial lab or through an interface with on site lab equipment.	DC.1.1.3.1	3.02, 3.03, 3.04, 3.08	
AM 09.03	AM	AM	Capture external clinical documents	Incorporate clinical documentation from external sources	The system shall provide the ability to save scanned documents as images.	P				DC.1.1.3.1	4.03	
AM 09.04	AM	AM	Capture external clinical documents	Incorporate clinical documentation from external sources	The system shall provide the ability to receive, store in the patient's record, and display text-based outside reports.			M	This could be either from an outside system or from scanning with optical character recognition.	DC.1.1.3.1	4.52	
AM 09.05	AM	AM	Capture external clinical documents	Incorporate clinical documentation from external sources	The system shall provide the ability to index and retrieve scanned documents based on the document type, the date of the original document.			N				
AM 09.06	AM	AM	Capture external clinical documents	Incorporate clinical documentation from external sources	The system shall provide access to clinical images. They must be accessible from within the patient's chart and labeled and date-time stamped or included in a patient encounter document. These images may be stored within the system or be provided through direct linkage to external sources.			N	These images may include but are not limited to radiographic, digital or graphical images. Eventually the goal would be to allow linkage to outside systems such as a hospital PAC system. The date/time stamp may be the date/time of image creation or acquisition, the date/time of image importation/incorporation into the system, date/time of the clinical encounter with which the image is associated, or manually entered by the user.	DC.1.1.3.1	4.52.02	

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AM 09.07	AM	AM	Capture external clinical documents	Incorporate clinical documentation from external sources	The system shall provide the ability to accept, store in the patient's record, and display clinical results received through an interface with an external source.	M			This is limited to clinical data received through interfaces as defined in CCHIT interoperability criteria. It is acceptable if certain data received through an interface, if not relevant to the end user, are not displayed in the application.	DC.1.1.3.1	4.13, 4.14, 4.15	
AM 09.08	AM	AM	Capture external clinical documents	Incorporate clinical documentation from external sources	The system shall provide the ability to accept, store in the patient's record, and display medication details from an external source.		N		External source may include a retail pharmacy, the patient, or another provider. Medication details include strength and sig. Does not imply that this date will populate the medication module; that functionality will be required in future. Year to be determined based on applicability of available standards.	DC.1.1.3.1		
AM 10.01	AM	AM	Generate and record patient-specific instructions	Generate and record patient-specific instructions as clinically indicated	The system shall provide access to patient instructions and patient educational materials, which may reside within the system or be provided through links to external sources.	P			An example would be a vaccine information statement. This item will be removed in 2009 when the corresponding Foundation criterion is tested.	DC.1.10	2.20	
AM 10.02	AM	AM	Generate and record patient-specific instructions	Generate and record patient-specific instructions as clinically indicated	The system shall have the ability to provide access to test and procedure instructions that can be customized by the physician or health organization. These instructions may reside within the system or be provided through links to external sources.	P			This item relates to customization of instructions, not to recording in patient record that instructions have been provided. This item will be removed in 2009 when the corresponding Foundation criterion is tested.	DC.1.10	2.25	AF 10.03
AM 10.03	AM	AM	Generate and record patient-specific instructions	Generate and record patient-specific instructions as clinically indicated	The system shall have the ability to provide access to patient-specific test and procedure instructions that can be customized by the physician or health organization; these instructions are to be given to the patient. These instructions may reside within the system or be provided through links to external sources.		N					AF 10.03.01
AM 10.04	AM	AM	Generate and record patient-specific instructions	Generate and record patient-specific instructions as clinically indicated	The system shall have the ability to provide access to patient-specific test and procedure instructions that can be customized by the physician or health organization; these instructions are to be given to the filler of the order. These instructions may reside within the system or be provided through links to external sources.		N					AF 10.03.02
AM 10.05	AM	AM	Generate and record patient-specific instructions	Generate and record patient-specific instructions as clinically indicated	The system shall provide the ability to record that patient specific instructions or educational material were provided to the patient.	P			This does not require automatic documentation.	DC.1.10	2.33	AF 10.04

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AM 10.06	AM	AM	Generate and record patient-specific instructions	Generate and record patient-specific instructions as clinically indicated	The system shall provide the ability to create patient specific instructions.	P				DC.1.10	2.33	AF 10.05
AM 10.07	AM	AM	Generate and record patient-specific instructions	Generate and record patient-specific instructions as clinically indicated	The system shall provide the ability to specify, modify and access a patient-specific care plan, e.g. an Asthma Action Plan, including the ability to specify medications and patient instructions.			N				AF 10.06
FN 17.01	FN	FN	17. Generate and Record Patient-Specific Instructions	Generate and record patient-specific instructions related to pre- and post-procedural and post-discharge requirements.	The system shall provide the ability to access and review medication information (such as patient education material or drug monograph). This may reside within the system or be provided through links to external sources.	P					1.54	FN.59
FN 17.02	FN	FN	17. Generate and Record Patient-Specific Instructions	Generate and record patient-specific instructions related to pre- and post-procedural and post-discharge requirements.	The system shall provide the ability to provide access to test and procedure instructions that can be customized by the end user.			N	These instructions may reside within the system or be provided through external links.			FN.64
AM 11.01	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to create prescription or other medication orders with sufficient information for correct filling and dispensing by a pharmacy.	M			The term pharmacy here refers to all entities which fill prescriptions and dispense medications including but not limited to retail pharmacies, specialty, and mail order pharmacies.	DC.1.7.1	1.51, 4.24, 4.66, 4.66 a,	
AM 11.02	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to record user and date stamp for prescription related events, such as initial creation, renewal, refills, discontinuation, and cancellation of a prescription.	P			Security to limit prescription writing is included in 1.1.2 below.	DC.1.7.1	1.51, 4.65	
AM 11.03	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to capture the identity of the prescribing provider for all medication orders.	M				DC.1.7.1	1.51	
AM 11.04	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to capture common content for prescription details including strength, sig, quantity, and refills to be selected by the ordering clinician.	P			We encourage the development of standard national abbreviations and that only approved abbreviations should be supported.	DC.1.7.1	1.51, 4.63, 4.63 a	AF 11.08
AM 11.05	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to receive and display information received through electronic prescription eligibility checking.	N			Will be required by e-prescribing. This criterion should maintain a record of whether the patient was eligible for coverage in the system.			AF 11.12
AM 11.06	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to display information received through health plan/payer formulary checking.			N	If this included medications already on the medication list, a duplicate should not be created (same date, medication, strength, and prescriber). Formulary checking refers to whether a particular drug is covered.	DC.1.7.1		AF 11.13
AM 11.07	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to reorder a prior prescription without re-entering previous data (e.g. administration schedule, quantity).	P				DC.1.7.1	4.34	AF 11.14

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AM 11.08	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to print and electronically fax prescriptions.	M				DC.1.7.1	1.52, 1.56	AF 11.15
AM 11.09	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to re-print and re-fax prescriptions.	M			This allows a prescription that did not come out of the printer, or a fax that did not go through, to be resent/reprinted without entering another prescription.		1.53, 1.58	AF 11.16
AM 11.10	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to submit prescriptions electronically.	M			See also line 166 (DC 3.2.2). Faxing for 2006, tentative electronic 2007 once standards are promulgated. This presupposes that the pharmacy is capable of receiving electronic prescriptions. This function relates to computer e-prescribing and not faxing.	DC.1.7.1		AF 11.17
AM 11.11	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to display a dose calculator for patient-specific dosing based on weight.	N			The intent is to allow input of dose-per-weight and patient weight and calculate the corresponding dose. The dose-per-weight might be directly inputted by a user at the time the dose calculation is to occur, or might have been inputted previously as the default for a particular medication. The output may be in terms that take into account a particular strength and dosage form of a medication (e.g. "5ml" or "2 tablets") OR may be simply in terms of the amount of the active drug component, i.e. based on the numerator unit of the dose-per-weight expression (e.g. "250 mg"). It is not required that the dose calculator automatically populate fields in the prescription itself. This would be an interim step until databases are available to calculate doses automatically. This item will be removed in 2009 when the corresponding Foundation criterion is tested.	DC.1.7.1	1.50	AF 11.18
AM 11.12	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to identify medication samples dispensed, including lot number and expiration date.	P			Lot numbers and expiration date could be entered in free text or encoded.	DC.1.7.1	4.91	AF 11.22
AM 11.13	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to prescribe fractional amounts of medication (e.g. 1/2 tsp, 1/2 tablet).	M				DC.1.7.1	1.55	AF 11.23

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AM 11.14	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to alert the user if the drug interaction information is outdated.	N			The drug database should have an "expiration date" based on the frequency of their updates such that when that date has passed, the user is alerted. This criterion applies if the system requires user action to provide database updates as opposed to providing them automatically.			AF 11.27
AM 11.15	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to allow the user to configure prescriptions to incorporate fixed text according to the user's specifications and to customize the printed output of the prescription.	P			This refers to the "written" output and language on the prescription such as specific language, dispense as written. For instance, users should be able to modify the format/content of printed prescriptions to comply with state Board of Pharmacy requirements.		1.57, 1.58	AF 11.28
AM 11.16	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to associate a diagnosis with a prescription.	P			This item will be removed in 2009 when the corresponding Foundation criterion is tested.		4.24	AF 11.29
AM 11.17	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to display the associated problem or diagnosis (indication) on the printed prescription.	P			At least one diagnosis shall be able to be displayed but the ability to display more than one is desirable. Associated problem or diagnosis can be non-structured data or structured data.		4.26	AF 11.30
AM 11.18	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to create provider specific medication lists of the most commonly prescribed drugs with a default dose, frequency, and quantity.	P					4.22	AF 11.32
AM 11.19	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to create provider specific medication lists of the most commonly prescribed drugs with a default route, dose, frequency, and quantity.		N		This criterion will subsume AF 11.32 when it comes into effect in 2009.			AF 11.32.01
AM 11.20	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to add reminders for necessary follow up tests based on medication prescribed.	N			Does not imply that this must be an automated process. It is acceptable if the system requires an action by the user, separate from the action of prescribing the medication, to configure the system to issue future reminders related to follow-up tests for the medication.		4.29	AF 11.33
AM 11.21	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability to automatically add reminders for necessary follow up tests based on medication prescribed.		N		As available through 3rd-party drug databases.			AF 11.33.01

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AM 11.22	AM	AM	Order medication	Create prescriptions or other medication orders with detail adequate for correct filling and administration	The system shall provide the ability for a user to select an order for a medication and exit the process of creating the order at some point prior to completion such that another user can access the order for subsequent review and completion.			N				AF 11.34
FN 07.01	FN	FN	07. Manage Medication Orders	Create prescriptions or other medication orders with detail adequate for correct filling and administration. Provide information regarding compliance of medication orders with formularies.	The system shall provide the ability to alert the user at the time a new medication is prescribed/ordered that drug interaction, allergy, and formulary checking will not be performed against the uncoded medication or free text medication.	N				4.27		FN.26
FN 07.02	FN	FN	07. Manage Medication Orders	Create prescriptions or other medication orders with detail adequate for correct filling and administration. Provide information regarding compliance of medication orders with formularies.	The system shall provide the ability to prescribe/order uncoded and non-formulary medications.	P				4.27		FN.29
FN 07.03	FN	FN	07. Manage Medication Orders	Create prescriptions or other medication orders with detail adequate for correct filling and administration. Provide information regarding compliance of medication orders with formularies.	The system shall provide the ability to maintain a coded list of medications including a unique identifier for each medication.	M				1.62		FN.30
FN 07.04	FN	FN	07. Manage Medication Orders	Create prescriptions or other medication orders with detail adequate for correct filling and administration. Provide information regarding compliance of medication orders with formularies.	The system shall provide end-users the ability to search for medications by generic or brand name.	P				1.49		FN.31
FN 07.05	FN	FN	07. Manage Medication Orders	Create prescriptions or other medication orders with detail adequate for correct filling and administration. Provide information regarding compliance of medication orders with formularies.	The system shall provide the ability to access reference information for prescribing/ordering.	N			The reference information may reside within the system or be provided through links to external sources.	4.25		FN.63
FN 07.06	FN	FN	07. Manage Medication Orders	Create prescriptions or other medication orders with detail adequate for correct filling and administration. Provide information regarding compliance of medication orders with formularies.	The system shall provide the ability to specify prescription/medication order details including strength, route, frequency and comments. Strength, route and frequency must be captured and maintained as discrete data.			N				FN.73
AM 12.01	AM	AM	Order diagnostic tests	Submit diagnostic test orders based on input from specific care providers	The system shall provide the ability to order diagnostic tests, including labs and imaging studies.	P			This includes physicians and authorized non-physicians.	DC.1.7.2.2	1.31, 1.48, 4.41	
AM 12.02	AM	AM	Order diagnostic tests	Submit diagnostic test orders based on input from specific care providers	The system shall provide the ability to capture the identity of the ordering provider for all test orders.	P					1.31, 1.48, 4.41	AF 12.03
AM 12.03	AM	AM	Order diagnostic tests	Submit diagnostic test orders based on input from specific care providers	The system shall provide the ability to capture appropriate order entry detail, including associated diagnosis.	P			including associated diagnoses. It is desirable that all information for medical necessity checking be captured.	DC.1.7.2.2	1.31, 1.48, 4.41	AF 12.05

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AM 12.04	AM	AM	Order diagnostic tests	Submit diagnostic test orders based on input from specific care providers	The system shall provide the ability to display user created instructions and/or prompts when ordering diagnostic tests or procedures.	P			Refers to diagnostic test or procedure specific instructions and/or prompts; not patient specific instructions and/or prompts. Instructions and/or prompts may be created by the system administrator. A 3rd party product may be used, providing that the instructions and/or prompts appear at the point of care.	DC.1.7.2.2	1.48	AF 12.06
AM 12.05	AM	AM	Order diagnostic tests	Submit diagnostic test orders based on input from specific care providers	The system shall provide the ability to relay orders for a diagnostic test to the correct destination for completion.	P			Mechanisms for relaying orders may include providing a view of the order, sending it electronically, or printing a copy of the order or order requisition.	DC.1.7.2.2	1.31, 1.37, 2.26	AF 12.07
AM 12.06	AM	AM	Order diagnostic tests	Submit diagnostic test orders based on input from specific care providers	The system shall have the ability to provide a view of active orders for an individual patient.	P			Additional sorts and filters may be provided by the vendors but not required.	DC.1.7.2.2	1.37	AF 12.08
AM 12.07	AM	AM	Order diagnostic tests	Submit diagnostic test orders based on input from specific care providers	The system shall have the ability to provide a view of orders by like or comparable type, e.g., all radiology or all lab orders.	P			May include filters or sorts.	DC.1.7.2.2	4.50	AF 12.09
AM 12.08	AM	AM	Order diagnostic tests	Submit diagnostic test orders based on input from specific care providers	The system shall provide the ability to view outstanding orders for all patients (as opposed to outstanding orders for a single patient).		N					AF 12.09.01
AM 12.09	AM	AM	Order diagnostic tests	Submit diagnostic test orders based on input from specific care providers	The system shall provide the ability for a user to select a test order exit the process of creating the order at some point prior to completion such that another user can access the order for subsequent review and completion.			N				AF 12.10
FN 09.01	FN	FN	09. Orders and Referral Management		The system shall provide the ability to require problem / diagnosis as an order component.	N					1.31, 4.42	FN.36
FN 09.02	FN	FN	09. Orders and Referral Management		The system shall provide the ability to view status information for ordered services.		N					FN.37
FN 09.03	FN	FN	09. Orders and Referral Management		The system shall provide the ability to set or configure what fields are required for a complete order by order type.			N				FN.68
FN 09.04	FN	FN	09. Orders and Referral Management		The system shall provide the ability to capture and maintain, as discrete data, a diagnosis/problem code or description associated with an order of any type (including a prescription/medication order).		N					FN.69
FN 09.05	FN	FN	09. Orders and Referral Management		The system shall provide the ability for cosigned orders to retain and display the identities of all providers who co-sign the order.		N					FN.70
FN 10.01	FN	FN	10. Order Set Templates	Create, capture, maintain and display order set templates based on patient data or preferred standards or other criteria.	The system shall provide the ability to define a set of items to be ordered as a group.	P			The intent is that the Order Set thus defined will be used across multiple patients on multiple occasions.		2.22	FN.38
FN 10.02	FN	FN	10. Order Set Templates	Create, capture, maintain and display order set templates based on patient data or preferred standards or other criteria.	The system shall provide the ability to modify order sets.	P					2.23	FN.39

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FN 10.03	FN	FN	10. Order Set Templates	Create, capture, maintain and display order set templates based on patient data or preferred standards or other criteria.	The system shall provide the ability to include in an order set order types including but not limited to medications, laboratory tests, imaging studies, procedures and referrals.	P					2.23	FN.40
FN 11.01	FN	FN	11. Manage Order Sets	Provide order sets based on provider input or system prompt.	The system shall provide the ability for individual orders in an order set to be selected or deselected by the user.	N					2.24	FN.41
FN 11.02	FN	FN	11. Manage Order Sets	Provide order sets based on provider input or system prompt.	The system shall provide the ability to allow users to search for order sets by name.		N					FN.42
FN 11.03	FN	FN	11. Manage Order Sets	Provide order sets based on provider input or system prompt.	The system shall provide the ability to apply drug-drug, drug-allergy and drug-disease interaction checking in the same way to orders placed through an order set as to orders placed individually.		N					FN.43
FN 11.04	FN	FN	11. Manage Order Sets	Provide order sets based on provider input or system prompt.	The system shall provide the ability to display orders placed through an order set either individually or as a group.	N					2.27	FN.44
AM 14.01	AM	AM	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	The system shall provide the ability to indicate normal and abnormal results based on data provided from the original data source.	P			As each lab has it's own normal values, these should be reflected in the indication as to whether a lab is normal or abnormal.	DC.1.8.3	2.03, 3.02, 3.03, 3.04	
AM 14.02	AM	AM	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	The system shall provide the ability to display numerical results in flow sheets and graphical form in order to compare results, and shall provide the ability to display values graphed over time.	P			It is desirable for the system indicate if abnormal results are high or low.	DC.1.8.3	4.13	
AM 14.03	AM	AM	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	The system shall provide the ability to display non-numeric current and historical test results as textual data.	P				DC.1.8.3	2.03, 4.52	
AM 14.04	AM	AM	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	The system shall provide the ability to notify the relevant providers (ordering, copy to) that new results have been received.	P			Examples of notifying the provider include but are not limited to a reference to the new result in a provider "to do" list or inbox.	DC.1.8.3	4.60	
AM 14.05	AM	AM	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	The system shall provide the ability to filter or sort results by type of test and test date.	P					4.14, 4.15	
AM 14.06	AM	AM	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	In areas where results from multiple patients are displayed, the system shall provide the ability to filter or sort results by patient.	N			Examples include in basket and report.		3.05	
AM 14.07	AM	AM	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	The system shall provide the ability to forward a result to other users.	P				DC.1.8.3	4.56	

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AM 14.08	AM	AM	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	The system shall provide the ability to link the results to the original order.	M			In the current year this link can be effected manually by changing the status of the order from pending to complete. Future requirements could automate this link for certain electronically received labs although the requirement should not require that all types of orders be electronically linked to the results since the variety of result formats can be quite large (PT consult, Diabetes education...) and even the variety of lab result formats can be wide.	DC.1.8.3	4.52	
AM 14.09	AM	AM	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	The system shall provide the ability for a user to attach a free text comment to a result that can be seen by another user who might subsequently view that result.	P				DC.1.8.3	4.53	
AM 14.10	AM	AM	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	The system shall provide the ability to associate one or more images with a non-numerical result.		N		Through direct storage or links to the data.	DC.1.8.3		
AM 14.11	AM	AM	Manage results	Route, manage and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	The system shall provide the ability for a user to whom a result is presented to acknowledge the result.	P			This is separate from audit trail.	DC.1.8.3	4.54	
AM 15.01	AM	AM	Manage consents and authorizations	Create, maintain and verify patient treatment decisions in the form of consents and authorizations when required.	The system shall provide the ability to capture scanned paper consent documents (covered in DC.1.1.3.1).	P				DC.1.3.3	1.39	
AM 15.02	AM	AM	Manage consents and authorizations	Create, maintain and verify patient treatment decisions in the form of consents and authorizations when required.	The system shall provide the ability to store, display and print patient consent forms.	P			Example: Consent forms stored in the computer which are capable of being signed by the patient with either an electronic pen or a digital signature once widely available.	DC.1.3.3	1.38	
AM 15.03	AM	AM	Manage consents and authorizations	Create, maintain and verify patient treatment decisions in the form of consents and authorizations when required.	The system shall display and provide the ability for patients to electronically sign consent forms using currently available digital signature standards. Electronically signed consent forms shall be maintained within the patient medical record.		N		Prior to the establishment of an official standard for digital signature, criterion can be met by capturing an image of the handwritten signature.			
AM 15.04	AM	AM	Manage consents and authorizations	Create, maintain and verify patient treatment decisions in the form of consents and authorizations when required.	The system shall provide the ability to store and display administrative documents (e.g. privacy notices).	M			Needed for HIPAA. Scanned copy is acceptable for current year.	DC.1.3.3	1.39	
AM 15.05	AM	AM	Manage consents and authorizations	Create, maintain and verify patient treatment decisions in the form of consents and authorizations when required.	The system shall provide the ability to chronologically display consents and authorizations.		N			DC.1.3.3	1.40	AF 15.06

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AM 16.01	AM	AM	Manage patient advance directives	Capture, maintain and provide access to patient advance directives	The system shall provide the ability to indicate that a patient has completed advance directive(s).	P			Important for appropriate use of resources at end of life and may just include a yes, no indication.	DC.1.3.2	4.03	
AM 16.02	AM	AM	Manage patient advance directives	Capture, maintain and provide access to patient advance directives	The system shall provide the ability to indicate the type of advance directives, such as living will, durable power of attorney, or a "Do Not Resuscitate" order.	P			This may be recorded in non-structured data or as discrete data.	DC.1.3.2	4.03	
AM 16.03	AM	AM	Manage patient advance directives	Capture, maintain and provide access to patient advance directives	The system shall provide the ability to indicate when advance directives were last reviewed.	P			This may be recorded in non-structured data or as discrete data.	DC.1.3.2	4.04	
AM 17.01	AM	AM	Support for standard care plans, guidelines, protocols	Support the use of appropriate standard care plans, guidelines and/or protocols for the management of specific conditions.	The system shall have the ability to provide access to standard care plan, protocol and guideline documents when requested at the time of the clinical encounter. These documents may reside within the system or be provided through links to external sources.	P			This requirement could be met by simply including links or access to a text document. Road map would require more comprehensive decision support in the future. This includes the use of clinical trial protocols to ensure compliance.	DC.2.2.1.1	1.32	
AM 17.02	AM	AM	Support for standard care plans, guidelines, protocols	Support the use of appropriate standard care plans, guidelines and/or protocols for the management of specific conditions.	The system shall provide the ability to create site-specific care plan, protocol, and guideline documents.	P			This includes the use of clinical trial protocols to ensure compliance. It is expected that in the future discrete data elements from other areas of the chart will populate matching fields.	DC.2.2.1.1	1.33	
AM 17.03	AM	AM	Support for standard care plans, guidelines, protocols	Support the use of appropriate standard care plans, guidelines and/or protocols for the management of specific conditions.	The system shall provide the ability to modify site-specific standard care plan, protocol, and guideline documents obtained from outside sources.	P				DC.2.2.1.1	4.17	
AM 18.01	AM	AM	Capture variances from standard care plans, guidelines, protocols	Identify variances from patient-specific and standard care plans, guidelines and protocols.	The system shall provide the ability to record the reason for variation from care plans, guidelines, and protocols as discrete data.		N		An example of this might be "patient refused." This item will be removed in 2009 when the corresponding Foundation criterion is tested.			
AM 19.01	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide the ability to check for potential interactions between medications to be prescribed and medication allergies and intolerances listed in the record and alert the user at the time of medication ordering if potential interactions exist.	P			This item will be removed in 2009 when the corresponding Foundation criterion is tested.	DC.2.3.1.1	4.34, 4.63, 4.63 a	AF 19.02
AM 19.02	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide the ability to check for potential interactions between medications ordered for administration (as opposed to prescriptions) and medication allergies and intolerances listed in the record and alert the user at the time of ordering if potential interactions exist.		N		'Ordered for administration' refers to administration at the site of care.			AF 19.02.01
AM 19.03	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide the ability to check for potential interactions between medications ordered for administration (as opposed to prescriptions) and current medications and alert the user at the time of ordering if potential interactions exist.		N		'Ordered for administration' refers to administration at the site of care.			AF 19.02.02

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AM 19.04	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide the ability to generate a report of items overridden. The report shall include date, provider, patient, interaction (drug-drug and drug-allergy) and reason for override.			N				AF 19.03.01
AM 19.05	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide the ability to set the severity level at which drug interaction warnings should be displayed.	P				DC.2.3.1.1	4.46	AF 19.04
AM 19.06	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall be capable, at the time of ordering a medication for administration (as opposed to prescribing), of alerting the user that based on the results of a laboratory test, the patient may be at increased risk for adverse effects of the medication.			N	'Ordered for administration' refers to administration at the site of care.			AF 19.07.01
AM 19.07	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide the ability to check whether a medication being prescribed has been noted to be ineffective for the patient in the past, and alert the user at the time of medication ordering if noted ineffectiveness exists.			N	This criterion assumes that at the time a medication was discontinued, it was marked "ineffective."	DC.2.3.1.1		AF 19.08
AM 19.08	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide the ability to display, on demand, potential interactions on a patient's medication list, even if a medication is not being prescribed at the time.	P			This item will be removed in 2009 when the corresponding Foundation criterion is tested.	DC.2.3.1.1	4.67	AF 19.09
AM 19.09	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide drug-disease interaction alerts at the time of medication ordering.			N	Within the limitations of available databases. This item will be removed in 2009 when the corresponding Foundation criterion is tested.		4.34	AF 19.10
AM 19.10	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide the ability to check for drug-disease interactions for medications ordered for administration (as opposed to prescriptions) and alert the user at the time of ordering if potential interactions exist.			N	'Ordered for administration' refers to administration at the site of care.			AF 19.10.01
AM 19.11	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide drug-disease interaction alerts at the time of entering a problem.			N				AF 19.10.02
AM 19.12	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide the ability to check for potential interactions between a current medication and a newly entered allergy.			N	This item will be removed in 2009 when the corresponding Foundation criterion is tested.			
AM 19.13	AM	AM	Support for drug interaction	Identify drug interaction warnings at the point of medication ordering	The system shall provide the ability to check for medication contraindications based on patient age for medications ordered for administration (as opposed to prescriptions) and alert the user at the time of ordering.			N	'Ordered for administration' refers to administration at the site of care.			AF 19.13.01
FN 12.01	FN	FN	12. Support for Drug Interaction checking	Identify drug interaction warnings at the time of medication ordering.	The system shall provide the ability to check for potential interactions between medications to be prescribed/ordered and current medications and alert the user at the time of medication prescribing/ordering if potential interactions exist.	P				DC.2.3.1.1	4.20, 4.34, 4.63, 4.63 a	FN.45
FN 12.02	FN	FN	12. Support for Drug Interaction checking	Identify drug interaction warnings at the time of medication ordering.	The system shall provide the ability to check immunization orders against documented patient allergies (medication and non-medication) and inform the user during prescribing/ordering.			N				FN.46

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FN 12.03	FN	FN	12. Support for Drug Interaction checking	Identify drug interaction warnings at the time of medication ordering.	The system shall provide the ability to, at the time of medication prescribing/ordering, alert the user that based on the results of a laboratory test, the patient may be at increased risk for adverse effects of the medication.		N	N				FN.49
FN 12.04	FN	FN	12. Support for Drug Interaction checking	Identify drug interaction warnings at the time of medication ordering.	The system shall provide the ability to display, on demand, potential allergies, drug-drug interactions and drug-disease interactions between current medications.		N					FN.50
FN 12.05	FN	FN	12. Support for Drug Interaction checking	Identify drug interaction warnings at the time of medication ordering.	The system shall provide the ability to view the rationale for a drug interaction alert.	N				4.35		FN.51
FN 12.06	FN	FN	12. Support for Drug Interaction checking	Identify drug interaction warnings at the time of medication ordering.	The system shall provide the ability to capture and maintain at least one reason for overriding any drug-drug or drug-allergy interaction warning triggered at the time of medication prescribing/ordering.	P				4.36, 4.65		FN.52
FN 12.07	FN	FN	12. Support for Drug Interaction checking	Identify drug interaction warnings at the time of medication ordering.	The system shall provide the ability to enter a structured response when overriding a drug-drug or drug-allergy warning.		N					FN.53
FN 12.08	FN	FN	12. Support for Drug Interaction checking	Identify drug interaction warnings at the time of medication ordering.	The system shall provide the ability to prescribe/order a medication despite alerts for interactions and/or allergies being present.	N				DC.2.3.1.1	4.20, 4.37, 4.64	FN.54
FN 12.09	FN	FN	12. Support for Drug Interaction checking	Identify drug interaction warnings at the time of medication ordering.	The system shall provide the ability to accept updates to drug interaction databases	P						FN.65
FN 12.10	FN	FN	12. Support for Drug Interaction checking	Identify drug interaction warnings at the time of medication ordering.	The system shall provide the ability to check for potential interactions between medications to be prescribed/ordered and medication allergies listed in the record and alert the user at the time of medication prescribing/ordering if potential interactions exist.		N					FN.71
FN 12.11	FN	FN	12. Support for Drug Interaction checking	Identify drug interaction warnings at the time of medication ordering.	The system shall provide the ability, when a new allergy is documented, to check for a potential interaction between the newly-documented allergy and the patient's current medications, and alert the user if such interactions exist.		N					FN.72
FN 13.01	FN	FN	13. Support for Medication Recommendations	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.	The system shall provide drug-diagnosis interaction alerts at the time of medication prescribing/ordering.		N					FN.47
FN 08.01	FN	FN	08. Medication & Immunization Ordering: Support for Patient -Specific Dosing and Warnings	Identify and present appropriate dose recommendations based on known patient conditions and characteristics at the time of medication ordering.	The system shall provide the ability to detect a daily dose that exceeds the recommended range for patient age and inform the user during ordering.		N					FN.27

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FN 08.02	FN	FN	08. Medication & Immunization Ordering: Support for Patient -Specific Dosing and Warnings	Identify and present appropriate dose recommendations based on known patient conditions and characteristics at the time of medication ordering.	The system shall provide the ability to display patient specific dosing recommendations based on renal function.			N				FN.28
FN 08.03	FN	FN	08. Medication & Immunization Ordering: Support for Patient -Specific Dosing and Warnings	Identify and present appropriate dose recommendations based on known patient conditions and characteristics at the time of medication ordering.	The system shall provide the ability to check for dose ranges based on patient age and weight.			N				FN.33
FN 08.04	FN	FN	08. Medication & Immunization Ordering: Support for Patient -Specific Dosing and Warnings	Identify and present appropriate dose recommendations based on known patient conditions and characteristics at the time of medication ordering.	The system shall provide the ability to display a dose calculator for patient-specific dosing based on weight.			N	The intent is to allow input of dose-per-weight and patient weight and calculate the corresponding dose. The dose-per-weight might be directly inputted by a user at the time the dose calculation is to occur, or might have been inputted previously as the default for a particular medication. The output may be in terms that take into account a particular strength and dosage form of a medication (e.g. "5ml or "2 tablets") OR may be simply in terms of the amount of the active drug component, i.e. based on the numerator unit of the dose-per-weight expression (e.g. "250 mg"). It is not required that the dose calculator automatically populate fields in the prescription itself. This would be an interim step until databases are available to calculate doses automatically.			FN.34
FN 08.05	FN	FN	08. Medication & Immunization Ordering: Support for Patient -Specific Dosing and Warnings	Identify and present appropriate dose recommendations based on known patient conditions and characteristics at the time of medication ordering.	The system shall provide the ability to display patient specific dosing recommendations based on age and weight.			N				FN.35
FN 08.06	FN	FN	08. Medication & Immunization Ordering: Support for Patient -Specific Dosing and Warnings	Identify and present appropriate dose recommendations based on known patient conditions and characteristics at the time of medication ordering.	The system shall provide the ability to check for medication contraindications based on patient age and alert the user during prescribing/ordering.			N				FN.48

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AM 20.01	AM	AM	Support for medication or immunization administration or supply	To reduce medication errors at the time of administration of a medication, the patient is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by-product of this checking; administration details and additional patient information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances patient education.	The system shall provide the ability to document medication administration.	P				DC.2.3.2	4.57	
FN 14.01	FN	FN	14. Support for Medication and Immunization Administration	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.	The system shall provide the ability to produce patient instructions and patient educational materials which may reside within the system or be provided through links to external source.		N		An example would be a vaccine information statement.			FN.56
FN 15.01	FN	FN	15. Manage Medication Administration	Present providers with the list of medications that are to be administered to a patient, necessary administration information, and capture administration details.	The system shall provide the ability to capture medication administration details as discrete data, including: (1) the medication name and dose; (2) date and time of administration; (3) route and site; (4) lot number and expiration date; (5) manufacturer; and (6) user ID.		N					FN.57
FN 16.01	FN	FN	16. Manage Immunization Administration	Capture and maintain discrete data concerning immunizations given to a patient including date administered, type, manufacturer, lot number, and any allergy or adverse reactions. Facilitate the interaction with an immunization registry to allow maintenance of a patient's immunization history.	The system shall provide the ability to capture an allergy/adverse reaction to a specific immunization.		N		This may be recorded in the general allergy/adverse reaction section of the patient record. At this time, reaction information may be stored as free text. In the future we anticipate this will need to be structured data.		1.45	FN.55
FN 16.02	FN	FN	16. Manage Immunization Administration	Capture and maintain discrete data concerning immunizations given to a patient including date administered, type, manufacturer, lot number, and any allergy or adverse reactions. Facilitate the interaction with an immunization registry to allow maintenance of a patient's immunization history.	The system shall provide the ability to capture, in a discrete field, an allergy/adverse reaction to a specific immunization.		N		This criterion will replace FN 16.01 when it comes into effect in 2009.			FN.55.01

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FN 16.03	FN	FN	16. Manage Immunization Administration	Capture and maintain discrete data concerning immunizations given to a patient including date administered, type, manufacturer, lot number, and any allergy or adverse reactions. Facilitate the interaction with an immunization registry to allow maintenance of a patient's immunization history.	The system shall provide the ability to capture immunization administration details as discrete data, including: (1) the immunization type and dose; (2) date and time of administration; (3) route and site; (4) lot number and expiration date; (5) manufacturer; and (6) user ID.	N			Compliance Key: P = Previous Criteria M = Modified for Year N = New for Year O = Provisional		1.42	FN.58
AM 21.01	AM	AM	Support for non-medication ordering (referrals, care management)		The system shall provide the ability to create referral orders with detail adequate for correct routing.	P			This could include referrals to sub-specialists, physical therapy, speech therapy, nutritionists, and other non-medication, non-clinical order. Adequate detail includes but is not limited to: • Date • Patient name and identifier • "Refer to" specialist name, address and telephone number • "Refer to" specialty • Reason for referral • Referring physician name	DC.2.4.2	2.30	
AM 21.02	AM	AM	Support for non-medication ordering (referrals, care management)		The system shall provide the ability to record user ID and date/time stamp for all referral related events.	P			Necessary for medico-legal purposes.	DC.2.4.2	2.30	
AM 22.01	AM	AM	Present alerts for disease management, preventive services and wellness	At the point of clinical decision making, identify patient specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routing preventive and wellness patient care standards.	The system shall provide the ability to establish criteria for disease management, wellness, and preventive services based on patient demographic data (minimally age and gender).	M				DC.2.5.1	1.13, 4.06	
AM 22.02	AM	AM	Present alerts for disease management, preventive services and wellness	At the point of clinical decision making, identify patient specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routing preventive and wellness patient care standards.	The system shall provide the ability to display alerts based on established guidelines.	M			Guidelines may be from national organizations, payers, or internal protocols.	DC.2.5.1	1.13	
AM 22.03	AM	AM	Present alerts for disease management, preventive services and wellness	At the point of clinical decision making, identify patient specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routing preventive and wellness patient care standards.	The system shall provide the ability to establish criteria for disease management, wellness, and preventive services based on clinical data (problem list, current medications).	P			Lab results in future years	DC.2.5.1	2.19	

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AM 22.04	AM	AM	Present alerts for disease management, preventive services and wellness	At the point of clinical decision making, identify patient specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routing preventive and wellness patient care standards.	The system shall provide the ability to update disease management guidelines and any associated reference material.	M			This allows the system's decision support tools to support changes in best practice guidelines. Associated reference material can be within the system or accessed through links to external sources.	DC.2.5.1	2.18	
AM 22.05	AM	AM	Present alerts for disease management, preventive services and wellness	At the point of clinical decision making, identify patient specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routing preventive and wellness patient care standards.	The system shall provide the ability to update preventive services/wellness guidelines and any associated reference material.	M			Associated reference material can be within the system or accessed through links to external sources.	DC.2.5.1	4.07	
AM 22.06	AM	AM	Present alerts for disease management, preventive services and wellness	At the point of clinical decision making, identify patient specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routing preventive and wellness patient care standards.	The system shall provide the ability to override guidelines.	M			The end user can override guidelines when appropriate to a specific clinical situation.	DC.2.5.1	4.08	
AM 22.07	AM	AM	Present alerts for disease management, preventive services and wellness	At the point of clinical decision making, identify patient specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routing preventive and wellness patient care standards.	The system shall provide the ability to document reasons disease management or preventive services/wellness prompts were overridden.	P			Needed for medico-legal reasons and clinical decision support.	DC.2.5.1	4.08	
AM 22.08	AM	AM	Present alerts for disease management, preventive services and wellness	At the point of clinical decision making, identify patient specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routing preventive and wellness patient care standards.	The system shall provide the ability to modify the rules or parameters upon which guideline-related alerts are based.	P			This is necessary for modifications as guidelines change or practices wish to adhere to more stringent levels for example, using a HbA1c target of 6.5% instead of 7%.	DC.2.5.1	4.10	
AM 22.09	AM	AM	Present alerts for disease management, preventive services and wellness	At the point of clinical decision making, identify patient specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routing preventive and wellness patient care standards.	The system shall provide the ability to document that a preventive or disease management service has been performed based on activities documented in the record (e.g., vitals signs taken).	P				DC.2.5.1	1.43	

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AM 22.10	AM	AM	Present alerts for disease management, preventive services and wellness	At the point of clinical decision making, identify patient specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routing preventive and wellness patient care standards.	The system shall provide the ability to document that a disease management or preventive service has been performed with associated dates or other relevant details recorded.	P			This could include services performed internally or external to the practice.	DC.2.5.1	4.09	
AM 22.11	AM	AM	Present alerts for disease management, preventive services and wellness	At the point of clinical decision making, identify patient specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routing preventive and wellness patient care standards.	The system shall provide the ability to individualize alerts to address a patient's specific clinical situation.	P			This is done at the patient level. Examples include but are not limited to: <ul style="list-style-type: none"> • Remove mammography for woman that has had a mastectomy • Remove annual pap smear alert for a woman who has had a complete hysterectomy. • Inactivate an alert for routine colon cancer screening in a patient who is terminally ill. 		2.21	
AM 23.01	AM	AM	Notifications and reminders for disease management, preventive services and wellness	Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	The system shall provide the ability to identify preventive services, tests or counseling that are due on an individual patient.	P				DC.2.5.2	1.13	
AM 23.02	AM	AM	Notifications and reminders for disease management, preventive services and wellness	Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	The system shall provide the ability to display reminders for disease management, preventive and wellness services in the patient record.	M				DC.2.5.2	1.13	
AM 23.03	AM	AM	Notifications and reminders for disease management, preventive services and wellness	Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	The system shall provide the ability to identify criteria for disease management, preventive and wellness services based on patient demographic data (age, gender).	P				DC.2.5.2	1.13	
AM 23.04	AM	AM	Notifications and reminders for disease management, preventive services and wellness	Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	The system shall provide the ability to identify criteria for disease management, preventive, and wellness services based on clinical data (problem list, current medications, lab values).	P				DC.2.5.2	2.17	

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AM 23.05	AM	AM	Notifications and reminders for disease management, preventive services and wellness	Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	The system shall provide the ability to modify the guidelines, criteria or rules that trigger the reminders.	M			This refers to any practice defined authorized user.	DC.2.5.2	1.14	
AM 23.06	AM	AM	Notifications and reminders for disease management, preventive services and wellness	Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	The system shall provide the ability to notify the provider that patients are due or are overdue for disease management, preventive or wellness services.	P				DC.2.5.2	1.13	
AM 23.07	AM	AM	Notifications and reminders for disease management, preventive services and wellness	Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	The system shall provide the ability to produce a list of patients who are due or are overdue for disease management, preventive or wellness services.	P				DC.2.5.2	4.84	
AM 23.08	AM	AM	Notifications and reminders for disease management, preventive services and wellness	Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	The system shall provide the ability to automatically generate letters to remind the patient or the patient's guardian of disease management, preventive, or wellness services that are due.	M			The term 'automatically' means that the system is able to generate patient recalls for all due or overdue reminders for an individual patient based on the current date, regardless of whether a user initiates this action, or if the action is triggered by pre-set parameters in the system. An example would be generating a letter to all patients overdue for a screening mammography. It is acceptable if the output allows generation of letters, such as a mail merge file.	DC.2.5.2	4.85	
AM 23.09	AM	AM	Notifications and reminders for disease management, preventive services and wellness	Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	The system shall provide the ability to automatically generate reminder letters for patients who are due or are overdue for disease management, preventive or wellness services.		N		This criterion will replace AF 23.08 when it comes into effect in 2009.			AF 23.08.01

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AM 23.10	AM	AM	Notifications and reminders for disease management, preventive services and wellness	Between healthcare encounters, notify the patient and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	The system shall provide the ability to automatically generate an electronic reminder to the patient or the patient's guardian of disease management, preventive, or wellness services that are due.			N	<p>The term 'automatically' means that the system is able to generate patient recalls for all due or overdue reminders for an individual patient based on the current date, regardless of whether a user initiates this action, or if the action is triggered by pre-set parameters in the system.</p> <p>The WG will work with Interoperability and other EPs to determine the appropriate certification year, based on availability of secure messaging criteria.</p>			AF 23.09
AM 24.01	AM	AM	Clinical task assignment and routing	Assignment, delegation and/or transmission of tasks to the appropriate parties.	The system shall provide the ability to create and assign tasks by user or user role.	P			Examples of tasks are messages, notifications, inbox items, worklist to-do's. This task assignment refers to internal users. External tasks would be handled under ordering section.	DC.3.1.1	1.08, 1.11, 2.32, 2.38	
AM 24.02	AM	AM	Clinical task assignment and routing	Assignment, delegation and/or transmission of tasks to the appropriate parties.	The system shall provide the ability to present a list of tasks by user or user role.	P			Examples of tasks are messages, notifications, inbox items, worklist to-do's. This task assignment refers to internal users. External tasks would be handled under ordering section.	DC.3.1.1	1.36	
AM 24.03	AM	AM	Clinical task assignment and routing	Assignment, delegation and/or transmission of tasks to the appropriate parties.	The system shall provide the ability to re-assign and route tasks from one user to another user.	P				DC.3.1.1	2.39, 2.42	
AM 24.04	AM	AM	Clinical task assignment and routing	Assignment, delegation and/or transmission of tasks to the appropriate parties.	The system shall provide the ability to designate a task as completed.	P				DC.3.1.1	1.41, 2.42	
AM 24.05	AM	AM	Clinical task assignment and routing	Assignment, delegation and/or transmission of tasks to the appropriate parties.	The system shall provide the ability to remove a task without completing the task.	P			Removing a task eliminates it from an individual user's "to do" list, not from audit logs, etc.	DC.3.1.1	1.11	
AM 24.06	AM	AM	Clinical task assignment and routing	Assignment, delegation and/or transmission of tasks to the appropriate parties.	The system shall provide the ability to automatically escalate incomplete tasks to the appropriate supervisor or authority.			N	Escalation can be based on elapsed time or time of day.	DC.3.1.1		
AM 25.01	AM	AM	Inter-provider communication	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other encounters) and generate paper message artifacts where appropriate.	The system shall provide the ability to document verbal/telephone communication into the patient record.	P				DC.3.2.1	2.31	

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AM 25.02	AM	AM	Inter-provider communication	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other encounters) and generate paper message artifacts where appropriate.	The system shall provide the ability to incorporate paper documents from external providers into the patient record.	P				DC.3.2.1	2.14	
AM 25.03	AM	AM	Inter-provider communication	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other encounters) and generate paper message artifacts where appropriate.	The system shall support messaging between users.	P			Results and other patient data could be included. As clarification, messaging is defined as any text string sent from one person to another in the office.	DC.3.2.1	1.08, 2.32, 2.38	
AM 26.01	AM	AM	Pharmacy communication	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	The system shall have the ability to provide electronic communication between prescribers and pharmacies or other intended recipients of the medication order.	P				DC.3.2.2	1.52	
AM 26.02	AM	AM	Pharmacy communication	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	The system shall provide the ability to electronically communicate from the prescriber to the pharmacy an initial medication order as well as renewals of an existing order.	P				DC.3.2.2		
AM 26.03	AM	AM	Pharmacy communication	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	The system shall provide the ability to capture and display any renewal requests received electronically from or on behalf of any dispensing entity.	P			This refers to e-prescribing.	DC.3.2.2		AF 26.04
AM 26.04	AM	AM	Pharmacy communication	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	The system shall provide the ability to capture and display notification of prior authorizations received electronically from or on behalf of any dispensing entity.			N	Dependent upon standards development and availability			AF 26.05

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AM 27.01	AM	AM	Provider demographics	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the practice of medicine.	The system shall provide the ability to maintain a directory of all clinical personnel who currently use or access the system.	P				S.1.3.1		
AM 27.02	AM	AM	Provider demographics	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the practice of medicine.	The system shall provide the ability to maintain a directory which contains identifiers required for licensed clinicians to support the practice of medicine including at a minimum state medical license, DEA, NPI, and UPIN number.	P			This directory may be the same as that in criterion #1 for this functionality.	S.1.3.1	2.28	
AM 27.03	AM	AM	Provider demographics	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the practice of medicine.	The system shall allow authorized users to update the directory.	P				S.1.3.1		AF 27.04
AM 27.04	AM	AM	Provider demographics	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the practice of medicine.	The system shall provide the ability to create and maintain a directory of clinical personnel external to the organization who are not users of the system to facilitate communication and information exchange.	P			This directory may be the same as that in criterion #1 for this functionality.	S.1.3.1	2.29	AF 27.05
AM 28.01	AM	AM	Scheduling	Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of patient care, for either the patient or a resource/device.	The system shall provide the ability to display a schedule of patient appointments, populated either through data entry in the system itself or through an external application interoperating with the system.	P				S.1.6	1.07	
AM 29.01	AM	AM	Report generation	Provide report generation features for the generation of standard and ad hoc reports	The system shall provide the ability to generate reports of clinical and administrative data using either internal or external reporting tools.	P			Needed for pay for performance, quality improvement activities. All data that is entered in a structured format should be individually reportable.	S.2.2	4.72, 4.74	
AM 29.02	AM	AM	Report generation	Provide report generation features for the generation of standard and ad hoc reports	The system shall provide the ability to generate reports consisting of all or part of an individual patient's medical record (e.g. patient summary).	P			Report format may be plain text.	S.2.2	1.15, 1.44, 4.45	
AM 29.03	AM	AM	Report generation	Provide report generation features for the generation of standard and ad hoc reports	The system shall provide the ability to generate reports regarding multiple patients (e.g. diabetes roster).	P			Any disease registry might be included.	S.2.2	4.72	
AM 29.04	AM	AM	Report generation	Provide report generation features for the generation of standard and ad hoc reports	The system shall provide the ability to specify report parameters (sort and filter criteria) based on patient demographic and clinical data (e.g., all male patients over 50 that are diabetic and have a HbA1c value of over 7.0 or that are on a certain medication).	P			Minimum demographic data are age and gender.	S.2.2	4.78, 4.79	

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AM 29.05	AM	AM	Report generation	Provide report generation features for the generation of standard and ad hoc reports	The system shall provide the ability to access reports outside the EHR application.	P			For example, printed output, export to a file, etc.	S.2.2	1.44	
AM 29.06	AM	AM	Report generation	Provide report generation features for the generation of standard and ad hoc reports	The system shall provide the ability to produce reports based on the absence of a clinical data element (e.g., a lab test has not been performed or a blood pressure has not been measured in the last year).		N			S.2.2		
AM 29.07	AM	AM	Report generation	Provide report generation features for the generation of standard and ad hoc reports	The system shall provide the ability to save report parameters for generating subsequent reports.	P				S.2.2	4.80, 4.81	
AM 29.08	AM	AM	Report generation	Provide report generation features for the generation of standard and ad hoc reports	The system shall provide the ability to modify one or more parameters of a saved report specification when generating a report using that specification.	M			It is acceptable if a 3rd-party reporting tool or application is used.	S.2.2	4.82	
AM 30.01	AM	AM	Health record output	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	The system shall provide the ability to define one or more reports as the formal health record for disclosure purposes.	P			This allows the practice to not print demographics, certain confidential sections, or other items. Report format may be plain text initially. In the future there will be a need for structured reports as interoperability standards evolve.	S.2.2.1	4.86	
AM 30.02	AM	AM	Health record output	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	The system shall provide the ability to generate hardcopy or electronic output of part or all of the individual patient's medical record.	P			This could include but is not limited to the ability to generate standardized reports needed for work, school, or athletic participation.	S.2.2.1	1.15, 1.44, 4.45	
AM 30.03	AM	AM	Health record output	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	The system shall provide the ability to generate hardcopy and electronic output by date and/or date range.	P				S.2.2.1	4.75, 4.76	

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AM 30.04	AM	AM	Health record output	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	The system shall provide the ability to export structured data which removes those identifiers listed in the HIPAA definition of a limited dataset. This export on hardcopy and electronic output shall leave the actual PHI data unmodified in the original record.	N			De-identifying data on hardcopy or electronic output is necessary for research. However, it must be emphasized that this function is not intended to cleanse the text in the note or data in the original record. As per HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, identifiers that shall be removed are: 1. Names; 2. Postal address information, other than town or city, state and zip code; 3. Telephone numbers; 4. Fax numbers; 5. Electronic mail addresses; 6. Social security numbers; 7. Medical record numbers; 8. Health plan beneficiary numbers; 9. Account numbers; 10. Certificate/license numbers; 11. Vehicle identifiers and serial numbers, including license plate numbers; 12. Device identifiers and serial numbers; 13. Web Universal Resource Locators (URLs); 14. Internet Protocol (IP) address numbers 15. Biometric identifiers, including finger and voice prints; and 16. Full face photographic images and any comparable images.	S.2.2.1	4.81	
AM 30.05	AM	AM	Health record output	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	The system shall provide the ability to create hardcopy and electronic report summary information (procedures, medications, labs, immunizations, allergies, and vital signs).	P			The report that's produced should be organized by section to make it easier to read.	S.2.2.1	1.44	
AM 30.06	AM	AM	Health record output	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	The system shall have the ability to provide support for disclosure management in compliance with HIPAA and applicable law.	P			This criterion may be satisfied by providing the ability to create a note in the patient's record. More advanced functionality may be market differentiators or requirements in later years.		4.87	
AM 31.01	AM	AM	Encounter management	Manage and document the health care delivered during an encounter	The system shall provide the ability to document a patient encounter.	P				S.3.1	2.08	

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AM 31.02	AM	AM	Encounter management	Manage and document the health care delivered during an encounter	The system shall provide the ability to document encounters by one or more of the following means: direct keyboard entry of text; structured data entry utilizing templates, forms, pick lists or macro substitution; dictation with subsequent transcription of voice to text, either manually or via voice recognition system.	P			This does not preclude entry via new technologies.	S.3.1	1.12, 2.08	
AM 31.03	AM	AM	Encounter management	Manage and document the health care delivered during an encounter	The system shall provide the ability to associate individual encounters with diagnoses.	P				S.3.1	2.34	
AM 31.04	AM	AM	Encounter management	Manage and document the health care delivered during an encounter	The system shall have the ability to provide filtered displays of encounters based on encounter characteristics, including date of service, encounter provider and associated diagnosis.	P				S.3.1	4.69	
AM 32.01	AM	AM	Rules-driven financial and administrative coding assistance	Provide financial and administrative coding assistance based on the structured data available in the encounter documentation.	The system shall have the ability to provide a list of financial and administrative codes.	P			For example, ICD-9 CM, ICD-10 CM, and CPT-4 codes.	S.3.2.2	2.36	
AM 32.02	AM	AM	Rules-driven financial and administrative coding assistance	Provide financial and administrative coding assistance based on the structured data available in the encounter documentation.	The system shall provide the ability to select an appropriate CPT Evaluation and Management code based on data found in a clinical encounter.	P			May be accomplished via a link to another application.	S.3.2.2	2.36	
AM 32.03	AM	AM	Rules-driven financial and administrative coding assistance	Provide financial and administrative coding assistance based on the structured data available in the encounter documentation.	The system shall have the ability to provide assistance with selecting an appropriate CPT Evaluation and Management billing code based on codified clinical information in the encounter.	N			Criterion satisfaction will require that the system can automatically count elements in the history and examination documentation to accomplish this calculation. MDM complexity may still require specification by the provider/coder.	S.3.2.2	2.36	
AM 33.01	AM	AM	Eligibility verification and determination of coverage	Identify relationships among providers treating a single patient, and provide the ability to manage patient lists assigned to a particular provider.	The system shall provide the ability to display medical eligibility obtained from patient's insurance carrier, populated either through data entry in the system itself or through an external application interoperating with the system.	P			The EHR need only provide information for the physician as to whether the patient is covered by that insurance plan. At this time this can be accomplished by a text note following telephone verification. In the future this data will need to be structured in compliance with evolving interoperability standards.	S.3.3.2	4.02	
AM 34.01	AM	AM	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.	The system shall provide the ability to specify the role of each provider associated with a patient, such as encounter provider, primary care provider, attending, resident, or consultant.	N			This is simply meant as a means to define the provider role. Display of that data is not addressed.	S.3.4	1.67	AF 34.02
AM 34.02	AM	AM	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.	The system shall provide the ability to specify the role of each provider associated with a patient, such as encounter provider, primary care provider, attending, resident, or consultant using structured data.	N			This is simply meant as a means to define the provider role. Display of that data is not addressed.	S.3.4		AF 34.02.01

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AM 35.01	AM	AM	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	The system shall provide the ability to update the clinical content or rules utilized to generate clinical decision support reminders and alerts.	P			Growth charts, CPT-4 codes, drug interactions would be an example. Any method of updating would be acceptable. Content could be third party or customer created.	S.3.7.1		
AM 35.02	AM	AM	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	The system shall provide the ability to update clinical decision support guidelines and associated reference material.	P			Any method of updating would be acceptable. Content could be third party or customer created.	S.3.7.1	4.07	
FN 18.02	FN	FN	18. Manage Documentation of Clinician Response to Decision Support Prompts		The system shall provide the ability to capture and maintain, as discrete data, the reason for variation from rule-based clinical messages (for example alerts and reminders).			N	An example would be "patient refused."			FN.74
AM 36.01	AM	AM	Enforcement of confidentiality	Enforce the applicable jurisdiction's patient privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	The system shall provide the ability to audit the date/time and user of each instance when a patient chart is printed by the system.	P			Does not include screen print and other functions that are outside the EHR system.	I.1.9	4.77	
AM 36.02	AM	AM	Enforcement of confidentiality	Enforce the applicable jurisdiction's patient privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	The system shall provide a means to document a patient's dispute with information currently in their chart.			N	This does not imply that the patient can document directly in their chart. Some methods include but are not limited to allowing the patient a view only access to their record, printing a copy of the record for a patient to review. Methods to include the information in the chart could be as a note, a scanned copy of patient comments, an addendum to the note or other method not described.	I.1.9	1.29	
AM 36.03	AM	AM	Enforcement of confidentiality	Enforce the applicable jurisdiction's patient privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	The system shall provide the ability to identify all users who have accessed an individual's chart over a given time period, including date and time of access.	P			Specific items/sections of information accessed shall be identified, with appropriate audit trail.	I.1.9	4.83	
AM 36.04	AM	AM	Enforcement of confidentiality	Enforce the applicable jurisdiction's patient privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	The system shall provide the ability to identify certain information as confidential and only make that accessible by appropriately authorized users.			N	This may be implemented by having a "confidential" section of the chart. In the future such confidential designation will be required at the data element level, e.g., individual problems on the problem list, medications, allergies, results, etc.	I.1.9	2.35, 2.43	

2008 Criteria #	Source WG	Certification Track	Category	Category Description	Criteria	Compliance			Discussion / Comments	Source or References	Test Script Reference	Internal WG #
						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
									<div style="border: 1px solid black; padding: 5px; width: fit-content;"> Compliance Key: P = Previous Criteria M = Modified for Year N = New for Year O = Provisional </div>			
AM 36.05	AM	AM	Enforcement of confidentiality	Enforce the applicable jurisdiction's patient privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	The system shall provide the ability to prevent specified user(s) from accessing a designated patient's chart.		M		An example would be to block a user who has a personal relationship with a patient from accessing that patient's chart.	I.1.9		
AM 36.06	AM	AM	Enforcement of confidentiality	Enforce the applicable jurisdiction's patient privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	When access to a chart is restricted, the system shall provide a means for appropriately authorized users to "break the glass" for emergency situations.		N					AF.36.05.01
AM 36.07	AM	AM	Enforcement of confidentiality	Enforce the applicable jurisdiction's patient privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	When access to a chart is restricted and the "break the glass" has occurred, the system shall provide the ability to audit this override.		N					AF.36.05.02
AM 37.01	AM	AM	Data retention, availability and destruction	Retain, ensure availability, and destroy health record information according to organizational standards. This includes Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	The system shall provide the ability to retain data until otherwise purged, deleted, archived or otherwise deliberately removed.		P			I.2.1		
AM 37.02	AM	AM	Data retention, availability and destruction	Retain, ensure availability, and destroy health record information according to organizational standards. This includes Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	The system shall provide a method for archiving health record information.		N		Archiving is used to mean information stored in a retrievable fashion without defining where or how it is stored.	I.2.1		

2008 Criteria #	Source WG	Certification Track	Category	Category Description	Criteria	Compliance			Discussion / Comments	Source or References	Test Script Reference	Internal WG #
						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
AM 37.03	AM	AM	Data retention, availability and destruction	Retain, ensure availability, and destroy health record information according to organizational standards. This includes Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	The system shall provide the ability to retrieve information that has been archived.		N		Retrieval does not imply restoration to current version of the software.			
AM 38.01	AM	AM	Audit trail	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.	The system shall provide the ability to log outgoing information exchange in an auditable form.		N		In future, the work group will clarify details of what should be included in the log, and revise timing of this criterion based on those elements, if required.	I.2.2		
AM 39.01	AM	AM	Extraction of health record information	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	The system shall provide the ability to export (extract) pre-defined set(s) of data out of the system.		P		For example, export of performance measures, ability to query data base, chronic disease management tools.	I.2.4	4.72	

2008 Criteria #	Source WG	Certification Track	Category	Category Description	Criteria	Compliance			Discussion / Comments	Source or References	Test Script Reference	Internal WG #
						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
AM 39.02	AM	AM	Extraction of health record information	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	The system shall provide the ability to import data into the system.	P			Data import implies receiving discrete data into the EHR in an automated manner as opposed to manual data entry or document scanning. This could be accomplished via a real time or batch interface or a manual data load.	I.2.4	3.02, 3.03, 3.04	
AM 39.03	AM	AM	Extraction of health record information	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	The system shall provide the ability to specify the intended destination of the extracted information.			N	The user may indicate to whom they are sending results. The lack of control of information once it leaves the practice is acknowledged.	I.2.4		AF 39.04
AM 40.01	AM	AM	Concurrent use	EHR system supports multiple concurrent physicians through application, OS and database.	The system shall provide the ability for multiple users to interact concurrently with the EHR application.	P				Ontario 5.6.1.a	4.94	
AM 40.02	AM	AM	Concurrent use	EHR system supports multiple concurrent physicians through application, OS and database.	The system shall provide the ability for concurrent users to simultaneously view the same record.	P				Ontario 5.6.1.a	4.95	
AM 40.03	AM	AM	Concurrent use	EHR system supports multiple concurrent physicians through application, OS and database.	The system shall provide the ability for concurrent users to view the same clinical documentation or template.	P				Ontario 5.6.1.a	4.97	
AM 40.04	AM	AM	Concurrent use	EHR system supports multiple concurrent physicians through application, OS and database.	The system shall provide protection to maintain the integrity of clinical data during concurrent access.	P			To prevent users from simultaneously attempting to update a record with resultant loss of data	Ontario 5.6.1.a, I.1.9	4.96	
IO-AM 07.01	IO	AM	7. Laboratory		The system shall provide the ability to receive and store general laboratory results (includes ability to differentiate preliminary results and final results and the ability to process a corrected result)			M	The test files are designed so that products implementing HL7 v2.5.1 standard will be found compliant. The test identifier will be encoded in LOINC, and will be drawn from among 52 common test codes. Refer to the 2008 CCHIT Laboratory Interoperability Test Instructions and Applicant Form for the list of these codes and more information on the current interoperability test procedures.	EHR Lab Reporting Interoperability Specification (HITSP v2.1, 2007 IS01), HL7 v2.5.1, LOINC 2008 CCHIT Interoperability Testing Instructions and Applicant Form	3.02, 3.03, 3.04	IA-01

2008 Criteria #	Source WG	Certification Track	Category	Category Description	Criteria	Compliance			Discussion / Comments	Source or References	Test Script Reference	Internal WG #
						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
IO-AM 07.02	IO	AM	7. Laboratory		The system shall provide the ability to receive and store microbiology laboratory results with organisms recorded as free-text	N			Organisms recorded as free-text in 2008	EHR Lab Reporting Interoperability Specification (HITSP v2.1, 2007 IS01), HL7 v2.5.1, LOINC 2008 CCHIT Interoperability Testing Instructions and Applicant Form	3.03	IA-02
IO-AM 07.03	IO	AM	7. Laboratory		The system shall provide the ability to receive and store microbiology laboratory results with organisms coded w/SNOMED-CT		M		Organisms coded w/SNOMED-CT for 2009	EHR Lab Reporting Interoperability Specification (HITSP v2.1, 2007 IS01), HL7 v2.5.1, SNOMED-CT		IA-02.1
IO-AM 07.04	IO	AM	7. Laboratory		The system shall provide the ability to receive and store microbiology laboratory results with sensitivity testing coded using LOINC	N				EHR Lab Reporting Interoperability Specification (HITSP v2.1, 2007 IS01), HL7 v2.5.1, LOINC 2008 CCHIT Interoperability Testing Instructions and Applicant Form	3.03	IA-02.2
IO-AM 07.05	IO	AM	7. Laboratory		The system shall provide the ability to respond to a query to share laboratory results			N	Part of ONC EHR-Lab Use Case Will work with Ambulatory Functionality WG to align functionality criteria and interoperability roadmap dates.	EHR Lab Reporting Interoperability Specification (HITSP v2.1, 2007 IS01), HL7 v3.0 CDA R2, IHE XDS-Lab		IA-03
IO-AM 07.06	IO	AM	7. Laboratory		The system shall provide the ability to utilize RxNorm where appropriate for Tox Screens		N			NLM - RxNorm - Tox Screens		IA-04
IO-AM 07.07	IO	AM	7. Laboratory		The system shall provide the ability to Utilize UCUM for coding of units for laboratory results			N		EHR Lab Reporting Interoperability Specification (HITSP v2.1, 2007 IS01) HL7 Code Set: http://aurora.regenstrief.org/UCUM/ucum.html		IA-05
IO-AM 07.08	IO	IO	7. Laboratory		The system shall provide the ability to receive units using a defined vocabulary for lab results			N	Further information is needed - the group is soliciting public comments	TBD		IA-06
IO-AM 07.09	IO	AM	7. Laboratory		The system shall provide the ability to handle OIDs (object identifiers) for Lab results		N			EHR Lab Reporting Interoperability Specification (HITSP v2.1, 2007 IS01)		IA-07
IO-AM 07.10	IO	AM	7. Laboratory		The system shall provide the ability to utilize unique identifiers for Placer Order Number and unique identifiers for Filler Order Number for Lab results	N	N			EHR Lab Reporting Interoperability Specification (HITSP v2.1, 2007 IS01)		IA-08
IO-AM 07.11	IO	AM	7. Laboratory		The system shall provide the ability to generate a CDA document that is consistent with the HL7 2.5.1 message for Lab documents			N		EHR Lab Reporting Interoperability Specification (HITSP v2.1, 2007 IS01) HL7 v2.5.1 HL7 v3.0 CDA R2		IA-09

2008 Criteria #	Source WG	Certification Track	Category	Category Description	Criteria	Compliance			Discussion / Comments	Source or References	Test Script Reference	Internal WG #
						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
IO-AM 07.12	IO	AM	7. Laboratory		The system shall provide the ability to send an order for a laboratory test			N	Further work is need on defining the ordering messages and codes for ordering tests, should include an EHR generated order number for tracking	EHR Lab Reporting Interoperability Specification (HITSP v2.1, 2007 IS01)		IA-10
IO-AM 07.13	IO	AM	7. Laboratory		The system shall provide the ability to send a query to check status of a test order			N	Part of a function for closing the orders loop as part of quality improvement. Also need to be able to detect orders not matched with results.	EHR Lab Reporting Interoperability Specification (HITSP v2.1, 2007 IS01)		IA-11
IO-AM 08.01	IO	AM	8. Imaging		The system shall provide the ability to launch DICOM image viewer, may be web-based.			N		WADO (Web Access to DICOM Persistent Objects) 2008 CCHIT Interoperability Testing Instructions and Applicant Form	4.52.01	IA-12
IO-AM 08.02	IO	AM	8. Imaging		The system shall provide the ability to receive imaging reports and view images, includes ECG and other images as well as radiology			N		IHE XDS-I Cross-Enterprise Image Information Sharing integration profile		IA-13
IO-AM 08.03	IO	AM	8. Imaging		The system shall provide the ability to send a query to other providers to share imaging results			N		IHE XDS-I Cross-Enterprise Image Information Sharing integration profile		IA-14
IO-AM 08.04	IO	AM	8. Imaging		The system shall provide the ability to respond to a query to share imaging results with other providers			N		IHE XDS-I Cross-Enterprise Image Information Sharing integration profile		IA-15
IO-AM 08.05	IO	AM	8. Imaging		The system shall provide the ability to order radiology tests			N		HL7 v2.5		IA-16
IO-AM 08.06	IO	AM	8. Imaging		The system shall provide the ability to schedule radiology tests			N		IHE XDS-I Procedure Scheduled		IA-17
IO-AM 09.01	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to send, store, and receive coded medication information			N	Will look to align with HITSP, med management use case	Consumer Empowerment Interoperability Specification (HITSP v3.0 2007 IS03) Summary Documents Using CCD Component (HITSP v2.1 2007 C32) Federal Medication Terminologies (FMT): NDC, RxNorm, UNII. SNOMED-CT		IA-18

2008 Criteria #	Source WG	Certification Track	Category	Category Description	Criteria	Compliance			Discussion / Comments	Source or References	Test Script Reference	Internal WG #
						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
IO-AM 09.02	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to display CCD documents, using a subset of the HITSP C32 specification for Allergy and Conditions content information, and file them as intact documents in the EHR	N			Source-Conditions and Allergy Subset includes the following content modules of the HITSP C32: Person Information, Healthcare Provider, Condition, Allergies and Drug Sensitivity, Information Source, Comments Consumer-Document Display (2008): requires the Document Consumer only to have the ability to display the document as requested. (it may not be able to locally import it in the patient record). 2008 CCHIT Interoperability Testing Instructions and Applicant Form	Summary Documents Using CCD Component (HITSP v2.1 2007 C32) Consumer Empowerment Interoperability Specification (HITSP v3.0 2007 IS03) Section 3.2.3.9 "Consumer-Document Display Subset"	3.08	IA-19
IO-AM 09.02	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to display CCD documents, using a subset of the HITSP C32 specification for Allergy and Conditions content information, file them as intact documents in the EHR, and import the discrete data from one or more of the entries in a structured form into the patient record. If coded data is present it shall be maintained or mapped to a local value.	N			Source-Conditions and Allergy-Coded Subset includes the following content modules of the HITSP C32: Person Information, Healthcare Provider, Condition, Allergies and Drug Sensitivity, Information Source, Comments Consumer-Discrete Data Import (2009): requires the Document Consumer to have the ability to import the discrete data from one or more of the entries in a structured form into the patient record. If coded data is present it shall be maintained or mapped to a local value. Note: The ability to display the full document content is to be supported even if this subset is not all stored discretely in the receiving system.	Summary Documents Using CCD Component (HITSP v2.1 2007 C32) Consumer Empowerment Interoperability Specification (HITSP v3.0 2007 IS03) Section 3.2.3.13 C32 "Consumer-Conditions and Allergy Discrete Data Import Subset"		IA-19

2008 Criteria #	Source WG	Certification Track	Category	Category Description	Criteria	Compliance			Discussion / Comments	Source or References	Test Script Reference	Internal WG #
						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
IO-AM 09.04	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to generate and format CCD documents with narrative sections and structured entries (discrete fields) as specified by the HITSP IS03/C32 specification of the Allergy and Conditions module subset. For 2008, the values within the structured entries do not have to use industry standard vocabularies/terminologies (such as RxNorm or SNOMED-CT)	N			Source-Conditions and Allergy Subset includes the following content modules of the HITSP C32: Person Information, Healthcare Provider, Condition, Allergies and Drug Sensitivity, Information Source, Comments 2008 – Generate HITSP C32 Document without the requirement to use coded Terminologies. Text will be acceptable without implementing SNOMED and RxNORM coding that will be required to conform to the full C32 specification. 2008 CCHIT Interoperability Testing Instructions and Applicant Form	3.09, 3.10, 3.11	IA-19.1	
IO-AM 09.05	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to generate and format CCD documents with narrative sections and structured entries (discrete fields) as specified by the HITSP IS03/C32 specification of the Allergy and Conditions module subset. Structured entries value sets must adopt industry-standard vocabularies/terminologies (such as RxNORM or SNOMED-CT).	O	N		Source-Conditions and Allergy-Coded Subset includes the following content modules of the HITSP C32: Person Information, Healthcare Provider, Condition, Allergies and Drug Sensitivity, Information Source, Comments 2009– Generate HITSP C32 Document with the required use of coded Terminologies as specified in the C32 for allergy information 2008 CCHIT Interoperability Testing Instructions and Applicant Form	3.12	IA-19.2	
IO-AM 09.06	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to send an electronic prescription to pharmacy	P				NCPDP Script Standard v8.1 (NEWRX)		IA-21
IO-AM 09.07	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to send text or coded allergy information with new electronic prescriptions via NCPDP Script v8.1 (NEWRX) using the free text field of the message drug segment (DRU 090).		N			NCPDP Script Standard v8.1 (NEWRX)		IA-22

2008 Criteria #	Source WG	Certification Track	Category	Category Description	Criteria	Compliance			Discussion / Comments	Source or References	Test Script Reference	Internal WG #
						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
IO-AM 09.08	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to send text or coded allergy information with new electronic prescriptions-via NCPDP Script v8.1 (NEWRX) using the free text field of the message drug segment (DRU 090).			M	(coded - 2010)	NCPDP Script Standard v8.1 (NEWRX)		IA-22.1
IO-AM 09.09	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to respond to a request for a refill sent from a pharmacy	P			Transaction is now wide spread use so that systems that send new prescriptions need to be ready to respond to requests for refills.	NCPDP Script Standard v8.1 (REFREQ, REFRES)		IA-23
IO-AM 09.10	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to send a cancel prescription message to a pharmacy	O	N		Sent by the prescriber to cancel a prescription that was sent previously	NCPDP Script Standard v8.1 (CANRX, CANRES)		IA-24
IO-AM 09.11	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to respond to a request for a prescription change from a pharmacy		N		Sent by the pharmacy to request that the prescriber make changes to a prescription before it is filled. Prescribing clinician must have the ability to view and respond to a request for a prescription change from a pharmacy.	NCPDP Script Standard v8.1 (RXCHG, CHGRES)		IA-25
IO-AM 09.12	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to send electronic prescription to pharmacy including structured and coded SIG instructions			N	Standard has been written and finalized, and currently under ballot but not implemented. It is expected to complete NCPDP process by July. Will work with Ambulatory WG to align functionality criteria and interoperability roadmap dates in preparation for next round of public comments.	NCPDP Script Standard v10.5		IA-26
IO-AM 09.13	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to send a query to verify prescription drug insurance eligibility and apply response to formulary and benefit files to determine coverage	N			An essential first step prior to sending a query for medication history or formulary information directed at prescription drug coverage.	X12 270/271/ CAQH CORE Phase I Rules		IA-27
IO-AM 09.14	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to capture and display formulary information from pharmacy or PBM (Pharmacy Benefits Manager) by applying eligibility response	N			Usually preceded by a query for insurance eligibility to verify potential source of data.	NCPDP Formulary and Benefit Standard Implementation Guide v1.0		IA-28
IO-AM 09.15	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to send a query for medication history to PBM or pharmacy to capture and display medication list from the EHR	N			Part of ONC CE-PHR Use Case, used effectively during Medicare Part D pilots.	NCPDP Script Standard v8.1 (RXHREQ, RXHRES) / NDC codes		IA-29
IO-AM 09.16	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to receive medication fulfillment history from a pharmacy		N		Sent by pharmacy after medication has been dispensed to the patient	NCPDP Script Standard v8.12 (RXFILL)		IA-30
IO-AM 09.17	IO	AM	9. Medications / ePrescribing		The system shall provide the ability to identify pharmacies that can receive prescriptions electronically		N			Participating Provider/ Pharmacy Directory		IA-31

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						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
IO-AM 10.01	IO	AM	10. Immunizations		The system shall provide the ability to send a report of patient immunizations to an immunization registry			N	<p>Compliance Key: P = Previous Criteria M = Modified for Year N = New for Year O = Provisional</p> <p>State immunization registries are not using uniform national standards at this time. The cvx and mvx vocabularies constitute an option for representing immunizations, but have not been addressed by HITSP at this time. Working Group will evaluate standards and options for future versions of HL7.</p>	Revised HL7 Standards (underway)		IA-32
IO-AM 10.02	IO	AM	10. Immunizations		The system shall provide the ability to send a query to retrieve immunization information from an immunization registry and import immunization record into the EHR			N	<p>State immunization registries are not using uniform national standards at this time. The cvx and mvx vocabularies constitute an option for representing immunizations, but have not been addressed by HITSP at this time. Working Group will evaluate standards and options immunizations.</p>	Revised HL7 Standards (underway) - HITSP Immunization use case		IA-33
IO-AM 11.01	IO	AM	11. Clinical Documentation		The system shall provide the ability to display CCD documents, using a subset of the HITSP C32 specification for Registration Summary information, and file them as intact documents in the EHR			N	<p>Source-Registration Subset includes the following Content Modules of the HITSP C32 Document: Person Information, Language Spoken, Support, Healthcare Provider, Insurance Provider, Pregnancy, Information Source, Comments, Advance Directives</p>	<p>Summary Documents Using CCD Component (HITSP v2.1 2007 C32)</p> <p>Consumer Empowerment Interoperability Specification (HITSP v3.0 2007 IS03) Section 3.2.3.9 "Consumer-Documents Display Subset"</p> <p>Consumer-Documents Display (2008): requires the Document Consumer only to have the ability to display the document as requested. (it may not be able to locally import it in the patient record).</p> <p>2008 CCHIT Interoperability Testing Instructions and Applicant Form</p>	3.08	IA-34.1

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						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
IO-AM 11.02	IO	AM	11. Clinical Documentation		The system shall provide the ability to display CCD documents, using a subset of the HITSP C32 specification for Registration Summary information, file them as intact documents in the EHR, and import the discrete data from one or more of the entries in a structured form into the patient record. If coded data is present it shall be maintained or mapped to a local value.		N		<p>Source-Registration-Coded Subset includes the following Content Modules of the HITSP C32 Document: Person Information, Language Spoken, Support, Healthcare Provider, Insurance Provider, Pregnancy, Information Source, Comments, Advance Directives</p> <p>Compliance Key: P = Previous Criteria M = Modified for Year N = New for Year O = Provisional</p>	<p>Summary Documents Using CCD Component (HITSP v2.1 2007 C32)</p> <p>Consumer Empowerment Interoperability Specification (HITSP v3.0 2007 IS03) Section 3.2.3.11 C32 "Consumer-Registration Discrete Data Import Subset"</p> <p>Consumer-Discrete Data Import (2009): requires the Document Consumer to have the ability to import the discrete data from one or more of the entries in a structured form into the patient record. If coded data is present it shall be maintained or mapped to a local value.</p> <p>Note: The ability to display the full document content is to be supported even if this subset is not all stored discretely in the receiving system.</p>		IA-34.2
IO-AM 11.03	IO	AM	11. Clinical Documentation		The system shall provide the ability to generate and format CCD documents with narrative sections and structured entries (discrete fields) as specified by the HITSP IS03/C32 specification of the Registration Information module subset. For 2008, the values within the structured entries do not have to use industry standard vocabularies/terminologies (such as RxNorm or SNOMED-CT)		N		<p>Source-Registration Subset includes the following Content Modules of the HITSP C32 Document: Person Information, Language Spoken, Support, Healthcare Provider, Insurance Provider, Pregnancy, Information Source, Comments, Advance Directives</p>	<p>Summary Documents Using CCD Component (HITSP v2.1 2007 C32)</p> <p>Consumer Empowerment Interoperability Specification (HITSP v3.0 2007 IS03) Section 3.2.3.1 C32 "Creator-Registration Subset"</p> <p>2008 – Generate HITSP C32 Document without the requirement to use coded Terminologies</p> <p>2008 CCHIT Interoperability Testing Instructions and Applicant Form</p>	3.09, 3.10, 3.11	IA-34.3

2008 Criteria #	Source WG	Certification Track	Category	Category Description	Criteria	Compliance			Discussion / Comments	Source or References	Test Script Reference	Internal WG #
						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
IO-AM 11.04	IO	AM	11. Clinical Documentation		The system shall provide the ability to generate and format CCD documents with narrative sections and structured entries (discrete fields) as specified by the HITSP IS03/C32 specification of the Registration Information module subset. Structured entries value sets must adopt industry-standard vocabularies/terminologies (such as RxNORM or SNOMED-CT).	O	N		Source-Registration-Coded Subset includes the following Content Modules of the HITSP C32 Document: Person Information, Language Spoken, Support, Healthcare Provider, Insurance Provider, Pregnancy, Information Source, Comments, Advance Directives 2009- Generate HITSP C32 Document with the required use of coded Terminologies as specified in the C32 for registration information 2008 CCHIT Interoperability Testing Instructions and Applicant Form	3.12	IA-34.4	
IO-AM 11.05	IO	AM	11. Clinical Documentation		The system shall provide the ability to display CCD documents, using a subset of the HITSP C32 specification for Medication and Immunization History information and file them as intact documents in the EHR	N			Source-Medication Subset includes the following content modules of the HITSP C32: Person Information, Healthcare Provider, Medications-Prescriptions and Non-Prescription, Information Source, Comments Consumer-Document Display (2008): requires the Document Consumer only to have the ability to display the document as requested. (it may not be able to locally import it in the patient record). 2008 CCHIT Interoperability Testing Instructions and Applicant Form	3.08	IA-35.1	

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						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
IO-AM 11.06	IO	AM	11. Clinical Documentation		The system shall provide the ability to display CCD documents, using a subset of the HITSP C32 specification for Medication and Immunization History information, file them as intact documents in the EHR, and import the discrete data from one or more of the entries in a structured form into the patient record. If coded data is present it shall be maintained or mapped to a local value		N		Medication and Immunization History-Coded Subset includes the following content modules of the HITSP C32: Person Information, Healthcare Provider, Medications-Prescriptions and Non-Prescription, Information Source, Comments Consumer-Discrete Data Import (2009): requires the Document Consumer to have the ability to import the discrete data from one or more of the entries in a structured form into the patient record. If coded data is present it shall be maintained or mapped to a local value. Note: The ability to display the full document content is to be supported even if this subset is not all stored discretely in the receiving system.	Summary Documents Using CCD Component (HITSP v2.1 2007 C32) Consumer Empowerment Interoperability Specification (HITSP v3.0 2007 IS03) Section 3.2.3.12 C32 "Consumer-Medication and Immunization Discrete Data Import Subset"		IA-35.2
IO-AM 11.07	IO	AM	11. Clinical Documentation		The system shall provide the ability to generate and format CCD documents with narrative sections and structured entries (discrete fields) as specified by the HITSP IS03/C32 specification of the Medication and Immunization History module subset. For 2008, the values within the structured entries do not have to use industry standard vocabularies/terminologies (such as RxNorm or SNOMED-CT)		N		Source-Medication Subset includes the following content modules of the HITSP C32: Person Information, Healthcare Provider, Medications-Prescriptions and Non-Prescription, Information Source, Comments 2008 – Generate HITSP C32 Document without the requirement to use coded Terminologies. Text will be acceptable without implementing SNOMED and RxNORM coding that will be required to conform to the full C32 specification. 2008 CCHIT Interoperability Testing Instructions and Applicant Form	Summary Documents Using CCD Component (HITSP v2.1 2007 C32) Consumer Empowerment Interoperability Specification (HITSP v3.0 2007 IS03) Section 3.2.3.12 C32 Section 3.2.3.3 C32 "Creator-Medication and Immunization History Subset"	3.09, 3.10, 3.11	IA-35.3

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						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
IO-AM 11.08	IO	AM	11. Clinical Documentation		The system shall provide the ability to generate and format CCD documents with narrative sections and structured entries (discrete fields) as specified by the HITSP IS03/C32 specification of the Medication and Immunization History module subset. Structured entries value sets must adopt industry-standard vocabularies/terminologies (such as RxNORM or SNOMED-CT).	O	N		Medication and Immunization History-Coded Subset includes the following content modules of the HITSP C32: Person Information, Healthcare Provider, Medications-Prescriptions and Non-Prescription, Information Source, Comments	Summary Documents Using CCD Component (HITSP v2.1 2007 C32) Consumer Empowerment Interoperability Specification (HITSP v3.0 2007 IS03) Section 3.2.3.4 C32 "Creator-Medication and Immunization History-Coded Subset" 2009- Generate HITSP C32 Document with the required use of coded Terminologies as specified in the C32 for medication history information 2008 CCHIT Interoperability Testing Instructions and Applicant Form	3.12	IA-35.4
IO-AM 11.09	IO	AM	11. Clinical Documentation		The system shall provide the ability to retrieve, display, store, and export a HITSP C/48 document		N			Biosurveillance Interoperability Specification (HITSP v2.1 2007 IS-02) Encounter Document Content Component (HITSP v2.1 C48)		IA-36
IO-AM 11.10	IO	AM	11. Clinical Documentation	XDS-Components	The system shall provide the ability to support IHE ITI (Integrating the Healthcare Enterprise, IT Infrastructure) Framework: Document Source - Provide and Register Document Set		N			IHE Cross-Enterprise Document Sharing (XDS) integration profile Manage sharing of documents Transaction Package (HITSP v2.2 2007 TP13) IHE XDS ITI-14: Register Document Set IHE XDS ITI-15: Document Source - Provide & Register Document Set		IA-37
IO-AM 12.01	IO	AM	12. Document Exchange		The system shall provide the ability to support IHE ITI (Integrating the Healthcare Enterprise, IT Infrastructure) Framework: Document Consumer - Query Registry Transaction, Retrieve Document Transaction		N			IHE Cross-Enterprise Document Sharing (XDS) integration profile Manage sharing of documents Transaction Package (HITSP v2.2 2007 TP13) IHE XDS ITI-16: Query Registry IHE XDS ITI-17: Retrieve Document		IA-38

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						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
IO-AM 12.02	IO	AM	12. Document Exchange		The system shall provide the ability to support optional transactions for the Document Source Actor from the IHE ITI (Integrating the Healthcare Enterprise, IT Infrastructure) Framework			N	TP-13 points directly to IHE ITI-TF-1 table 10.2: XDS Actors and Options. Of note are the options for Document Source: offline, multiple document submission, document life cycle management, folder management. Coming - a change to this table listing Document Replace as a separate option.	IHE ITI Framework: Document Source Actor - optional transactions Manage sharing of documents Transaction Package (HITSP v2.2 2007 TP13)		IA-39
IO-AM 12.03	IO	AM	12. Document Exchange		The system shall provide the ability to support XDS.b Connectivity: Cross-Enterprise Document Sharing - Access an IHE XDS registry for clinical documents			N	XDS.b provides a new implementation choice for the Cross-Enterprise Document Sharing (XDS) Integration Profile based on a use of the Web Services and ebXML Registry/Repository standards that is consistent with the current developments and best practices in the industry.	IHE Cross-Enterprise Document Sharing (XDS)		IA-40
IO-AM 12.04	IO	AM	12. Document Exchange		The system shall provide the ability to access, display, store, and send documents in a PDF format using Cross-enterprise scanned document Sharing			N		XDS-SD: Cross-enterprise Sharing of Scanned Documents		IA-41
IO-AM 13.01	IO	AM	13. Chronic Disease Management / Patient Communication		The system shall ensure secure electronic messaging with patients			N	Part of AHIC Remote Consultation Breakthrough, standards and implementation guides have not been selected yet	Standards to be selected		IA-42
IO-AM 13.02	IO	AM	13. Chronic Disease Management / Patient Communication		The system shall provide the ability to import home physiologic monitoring data from patients			N	Remote Monitoring, standards and implementation guides have not been selected yet	Standards to be selected		IA-43
IO-AM 14.01	IO	AM	14. Population Health		The system shall provide the ability to send patient specific Public Health Disease Report for a reportable disease			N	Electronic replacement for traditional reportable disease notifications to health departments, may become part of biosurveillance in the future.	CDC Disease registries, Public Health Information Network (PHIN)		IA-44
IO-AM 14.02	IO	AM	14. Population Health		The system shall provide the ability to send de-identified utilization and laboratory bio-surveillance data to public health agencies			N	ONC Biosurveillance Use Case	Biosurveillance Interoperability Specification (HITSP v2.1 2007 IS-02); clinical content to be selected by the bio-surveillance data committee		IA-45
IO-AM 14.03	IO	AM	14. Population Health		The system shall provide the ability to report on Quality Improvement			N	Standards and implementation guides are not available yet and will be evaluated by the Work Group. An AHIC Quality Workgroup is developing interoperability specs targeted for HITSP approval in late 2007.	HITSP - IS06 - Quality V1.0		IA-46
IO-AM 15.01	IO	AM	15. Administrative and Financial Data		The system shall provide the ability to query and receive electronic medical insurance eligibility information			N	IOEP will reconcile with IO-AM 09.13.	X12 270/271/ CAQH CORE Phase I Rules		IA-47

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IO-AM 15.02	IO	AM	15. Administrative and Financial Data		The system shall provide the ability to send a query to coordinate patient identification		N		This criteria refers to coordination of patient identification between an EHR and a separate practice management system if one is used that will be done using HL7 ADT transactions. There is also the task of patient identification coordination that will be done with an HIE using PIX/PDQ transactions.	Patient ID Cross-Referencing Transaction Package (HITSP v2.0 2007 TP22) Patient Demographic Query Transaction (HITSP v2.0 2007 T23)		IA-48
IO-AM 15.03	IO	AM	15. Administrative and Financial Data		The system shall provide the ability to receive patient registration data from an outside system		N		Transfer of registration and patient identification data between practice management systems and EHR is very desirable. Although earlier certification is desirable, without implementation guides, certification cannot happen.			IA-50
IO-AM 15.04	IO	AM	15. Administrative and Financial Data		The system shall provide the ability to receive patient registration data from an internal practice management system		N		Because of widespread use of bundled systems, demonstration of functional registration data transfer between the PMS and EHR may be sufficient without selecting a specific transaction or method to accomplish the data transfer.	Functional Integration		IA-51
IO-AM 15.05	IO	AM	15. Administrative and Financial Data		The system shall provide the ability to receive scheduling information from a scheduling system		N		Transfer of data between a practice management scheduling system and an EHR is highly desirable and is essential for some EHR operations. Although earlier certification is desirable, without implementation guides, certification cannot happen.	HL7 2.4 Scheduling		IA-52
IO-AM 15.06	IO	AM	15. Administrative and Financial Data		The system shall provide the ability to send a query from the EHR to a scheduling system to schedule an appointment		N		The ability to schedule an appointment during a patient encounter will require new standards	Standards to be selected		IA-53
IO-AM 15.07	IO	AM	15. Administrative and Financial Data		The system shall provide the ability to receive electronic authorization for referral from payer		N		Only a handful of insurers are supporting this today.	X12 278 - Health Care Services Review: Referral Certification and Authorization - Dental, Professional, Institutional		IA-54
IO-AM 16.01	IO	AM	16. Clinical Trials		The system shall provide the ability to respond to query to Identify patients eligible for a clinical trial		N		Clinical trial will send eligibility criteria, EHR will identify patients for review by practice and respond with a count of potentially eligible patients and an intent to participate or not participate in the trial	NCI CABIG, CDISC		IA-55
IO-AM 16.02	IO	AM	16. Clinical Trials		The system shall provide the ability to send data to register a patient in a clinical trial		N		Will include informed consent	NCI CABIG, CDISC		IA-56
IO-AM 16.03	IO	AM	16. Clinical Trials		The system shall provide the ability to receive clinical trial protocol and templates for data collection		N		Will include clinical trial protocol and data collection templates	NCI CABIG, CDISC		IA-57
IO-AM 16.04	IO	AM	16. Clinical Trials		The system shall provide the ability to send data report to a clinical trial		N		Will require digital signature to assure authentication, integrity, and non-repudiation	NCI CABIG, CDISC		IA-58

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						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
PC 01.01			1. Access Control	Collect and Communicate Audit Trail	Provide assurance that security policies are being followed or enforced and that risks are being mitigated. Define and identify security relevant events and the data to be collected and communicated as determined by policy, regulation, or risk analysis. It also provides the mechanism to determine the record format to support analytical reports that are needed.			N	Road mapped to align with HITSP.	Health Information Technology Standards Panel (HITSP).		new
PC 01.02	PC	FN	1. Access Control	Authorship and Documentation	The system shall preserve incomplete note version at user log-out events or at elapsed time intervals configurable by the system administrator .			N		This is a modification of SC 03.03.		PC.10a
PC 01.03	PC	FN	1. Access Control	Authorship and Documentation	The system shall support the identification of original source author and date/time of documentation that is originated in prior encounters and brought into a current encounter using system functions. When system tools (examples are templates or defaults) are used to create an encounter note, the use of this mechanism should be retained in an edit trail for each portion of a note for which it was used.			N	New Audit Function: Standardized documentation that represents an encounter as created in total on a given day when actually created as a default again raises concerns about its date of authorship and its accuracy in representing actual services provided. CMS has stated that copy forward does not meet the documentation requirements for medical necessity.			PC.12a
PC 01.04	PC	FN	1. Access Control	Authorship and Documentation	The system shall have the ability to transmit clinical information to other information systems using standards that retain the available level of coding and structure, such as the HL7 Clinical Data Architecture.			N		MRET RTI Report		PC.14a
PC 01.05	PC	FN	1. Access Control	Authorship and Documentation	The system shall audit the receipt of documents and capture and retain the author and source of the document.			N		AFWG Criteria		PC.15a
PC 01.06	PC	FN	1. Access Control	New Audit Function	The system's audit log should remain operational whenever the system is operational for any user functions when in operation except for unavoidable technical circumstances (e.g. software problems, technical failure, full storage capacity, etc.) Deletions or alteration of the contents of the audit log will not be allowed by users. System must support a user-friendly output version of the audit log for transmission, printing, or export, which shows all details of events.			N	The audit log should remain operational whenever the system is operational for any user functions	MRET RTI Report		PC.17a
PC 01.07	PC	FN	1. Access Control	Access	The system shall provide the identify of the user and provide the ability to access, view and print patient data from previous admissions and/or office encounters by document type, identify of person and reason for access.			N				PC.1a

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PC 01.08	PC	FN	1. Access Control	User Identification and tracking	The system shall provide the identity of the user who prints a problem / diagnosis list in an audit report and this should be retained in the audit trail.		N		Definition of terms for the Privacy recommendation: Edit Trail - when edits are made to finalized documentation that are part of the patient record - these types of changes are tracked in the edit trail. Audit trail - refers to "behind the scenes" tracing of access which are Security criteria. The Privacy & Compliance EP recommendations for criteria are the original and addended note is part of the edit trail and metadata, but not part of the audit trail.	Inpatient functionality criteria.		PC.4a
PC 01.09	PC	FN	1. Access Control	Retaining data and time	The system shall record the identity of each user contributing to a note and will associate the identity of each to his/her entire contribution to all versions of the note (from intermediate and final versions of the note).		N		Clarification of retention vs. display: The edit trail is in the background with only the current (most recent) displayed (after edits are saved).	AHIMA e-HIM Work Group on Maintaining the Legal EHR. "Update: Maintaining a Legally Sound Health Record—Paper and Electronic." Journal of AHIMA 76, no.10 (November-December 2005): 64A-L.AHIMA e-HITM Work Group: Guidelines for EHR Documentation Practice.		PC.5a
PC 01.10	PC	FN	1. Access Control	Amendments and Corrections	The system shall track amendments made to the patient's chart when the original documentation was intended for a different patient without disclosing the identity of the other patient.		N		Note: This is amending a correction in another patient's EHRs.			PC.7a
PC 01.11	PC	FN	1. Access Control	Authorship and Documentation	The system shall provide the ability to identify the full content of a modified note, both the original content and the content resulting after any changes, corrections, clarifications, addenda, etc. to a finalized note, and retain amendments and corrections made to the patient's document for edit trail.		N		Current requirement allows certification of EHRs that do not preserve the original (intermediate versions) documentation of a finalized note. Definition of terms for the Privacy recommendation: Edit Trail - when edits are made to finalized documentation that are part of the patient record - these types of changes are retained in the edit trail. Audit trail - refers to "behind the scenes" tracing of access which are Security criteria.	ASTM E 2107-99 on Amendments (also addresses a number of versioning issues for non-finalized notes)		PC.8a
PC 01.12	PC	FN	1. Access Control	Authorship and Documentation	The system shall record date and time, and display the identity of the user who addended or corrected a note, as well as the reason for the change (amendment).		N		Modify existing criteria: Current requirements allow certification of EHRs that do not require recording of a reason for the change. This is a fundamental requirement for a legal business record and a legal medical record, as well as a standard of practice	ASTM E 2107-99 on Amendments (also addresses a number of versioning issues for non-finalized notes)		PC.9a
PC 02.01	PC	FN	2. Consent	Patient Consent	The system shall send Current Listing of Allergies to outpatient documentation sources (e.g., Physicians office EMR), or RHIO/network		N			JCAHO Requirement - med list must be forwarded to next provider.		PC.19a

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PC 02.02	PC	FN	2. Consent	Patient Consent Directives	The system shall capture and transfer patient consent directives. Patient consent directives are instances of governing jurisdictional and organization privacy policies that define specific aspects of the collections, access use and disclosure.			N	Road mapped to align with HITSP.	Health Information Technology Standards Panel (HITSP).		PC.20a
PC 03.01	PC	FN	3. Consistent Time	Ensure that all of the entities that are communicating within the network have synchronized system clocks.	The system shall be able to ensure that all of the entities that are communicating within a network have synchronized system clocks which is adhering to the standards identified and recommended by the Health Information Technology Standards Panel (HITSP)			N	Compliance: same time for all systems/interoperability and network; Roadmapped to align with HITSP	Health Information Technology Standards Panel		PC.21a
PC 04.01	PC	FN	4. Data Integrity Auditability	Data Integrity	The system shall require documentation of the audit support functionality in the vendor provided user guides and other support documentation, including how to identify and retrospectively reconstruct all data elements in the audit log including date, time.			N		Existing CCHIT Security Criteria and "Recommended Requirements for Enhancing Data Quality in Electronic Health Records Systems" aka "MRET Anti-Fraud Report"		PC.24a
PC 04.02	PC	FN	4. Data Integrity Auditability	Data Integrity	The system shall have the capacity to allow authorized entities read-only access to the EHR according to agreed upon uses and only as part of an identified audit subject to appropriate authentication, authorization, and access control functionality. Such access controls shall also support the applicable release of information protocols, local audit policies, minimum necessary criteria, and other contractual arrangements and laws, and require "auditor" be a supported class of user.			N		Existing CCHIT Security Criteria and "Recommended Requirements for Enhancing Data Quality in Electronic Health Records Systems" aka "MRET Anti-Fraud Report"		PC.25a
PC 04.03	PC	FN	4. Data Integrity Auditability	Data Integrity	The system shall provide the ability to destroy, deactivate, or archive EHR data/records in a systematic way in accordance to industry standard (according to the EHR system owner's policies and after legally prescribed retention periods).			N		Existing CCHIT Criteria and "Recommended Requirements for Enhancing Data Quality in Electronic Health Records Systems" aka "MRET Anti-Fraud Report"		PC.27a
PC 04.04	PC	FN	4. Data Integrity Auditability	Data Integrity	The system shall have the capacity to allow authorized entities 'read-only' access to the EHR according to agreed upon uses and only as part of an identified audit subject to appropriate authentication, authorization, and access control functionality.			N		Existing CCHIT Criteria and "Recommended Requirements for Enhancing Data Quality in Electronic Health Records Systems" aka "MRET Anti-Fraud Report"		PC.28a

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PC 04.05	PC	FN	4. Data Integrity Auditability	Data Integrity	System will provide the capability to produce a business version of a clinical document which indicates: * Date/time/user stamp for each entry *The methods used in the creation of the entry including but not limited to * Direct entry via integrated hardware keyboard or mouse *Speech recognition *Automated, machine-entered default information *Precreated documentation via form or template * Copy/import of an object including date/time user stamp of original author *Copy forward previous note contents, including date/time user stamp of original author * Dictation/transcription *Import from an external system.			N		Recommended Requirements for Enhancing Data Quality in Electronic Health Records Systems		PC.29a
PC 04.06	PC	FN	4. Data Integrity Auditability	Data Integrity	The system shall retain date/time/user stamp of original data entry person when data entered "on behalf" of another author.			N		Existing CCHIT Criteria and "Recommended Requirements for Enhancing Data Quality in Electronic Health Records Systems" aka "MRET Anti-Fraud Report"		PC.30a
PC 04.07	PC	FN	4. Data Integrity Auditability	Data Integrity	The system shall retain date/time/user stamp for an assistant that is entering data that will subsequently be signed by a provider, retain the date/time/use stamp of the data entry person as well as the provider.			N		Existing CCHIT Criteria and "Recommended Requirements for Enhancing Data Quality in Electronic Health Records Systems" aka "MRET Anti-Fraud Report"		PC.31a
PC 04.08	PC	FN	4. Data Integrity Auditability	Data Integrity	The system shall require retention of the original and amended note after "signature event" (including automatic "closing" of record).			N		Existing CCHIT Criteria Roadmap and "Recommended Requirements for Enhancing Data Quality in Electronic Health Records Systems" aka "MRET Anti-Fraud Report"		PC.32a
PC 04.09	PC	FN	4. Data Integrity Auditability	Traceability	The system shall provide a traceable and auditable path for the clinical documentation associated and substantiating billing/claim information.			N		Recommended Requirements for Enhancing Data Quality in Electronic Health Records Systems		PC.34a
PC 04.10	PC	FN	4. Data Integrity Auditability	National Provider Indicator	The system shall support the use of the National Provider Identifier or NPI in the EHR audit log to identify the individual provider or, in situations when an NPI is not available for an individual, a single unique internal provider identifier is assigned.			N		Existing CCHIT Criteria and "Recommended Requirements for Enhancing Data Quality in Electronic Health Records Systems" aka "MRET Anti-Fraud Report"		PC.35a

Compliance Key:
P = Previous Criteria
M = Modified for Year
N = New for Year
O = Provisional

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PC 05.01	PC	FN	5. EHRs Traceability	EHRs Traceability	The system shall allow an authorized administrator to set the inclusion or exclusion of audited events based on organizational policy and operating requirements/limits.			N		Existing CCHIT Criteria and MRET RTI Report		PC.39a
PC 05.02	PC	FN	5. EHRs Traceability	Data Integrity-Documentation Traceability (Output)	The system shall demonstrate the ability to generate and embed a transaction ID tracking number to patient chart outputs or exports, unique for each instance when a patient chart output/document is printed, electronically communicated, or otherwise exported			N		Recommended Requirements for Enhancing Data Quality in Electronic Health Records Systems		PC.41a
PC 06.01	PC	FN	6. Entity Identity Assertion	Ensure that an entity is the person or application that claims the identity provided.	The system shall be able to support the assurance that an entity is the person or application that attests to the identity provided and be compliant with the standards identified and recommended by the Health Information Technology Standards Panel (HITSP)			N		Health Information Technology Standards Panel		PC.37a
PC 07.01	PC	FN	7. Legal Business Record	Verbal Order documentation	The system shall provide the ability to document a verbal order, including the clinician taking (receiving) the verbal order, date and time of each transaction and the ordering physician in the patient record.			N		DC.2.3.1		PC.42a
PC 07.02	PC	FN	7. Legal Business Record	HITSP - standard nomenclature;	The system shall provide the ability to spell out UNITS, use Thousands and Millions as part of expressing large doses and allow the use of commas in doses expressed in thousands in dosage fields in medication orders and medication lists.			N		JCAHO Patient Safety Standards; HITSP; HL7		PC.43a
PC 07.03	PC	FN	7. Legal Business Record	View complete order and medication history	The system shall provide the ability to view the complete order and medication administration history, once HITSP defines interoperability specifications for NCP for medication history (12/07 comment period) (for the Roadmap only)			N				PC.45a
PC 07.04	PC	FN	7. Legal Business Record	Synchronization among primary and associated systems	The system shall demonstrate synchronization among primary certified system and associated systems (partner vendors) in the following categories: -Interaction with entity directories; -Linkage of received data with existing entity records; -Location of each health record and -Communication of changes between key systems.			N		HL7 Legal EHR-S Functional Profile IN2.3 (Registration Release 1, June 1, 2007)		PC.47a
PC 07.05	PC	FN	7. Legal Business Record	Non Repudiation	The system shall limit an EHR-S user's ability to deny (repudiate) the origination, receipt, or authorization of a data exchange by that user so that the source of the data record can not later deny that it is the source; that the sender or receiver of a message cannot later deny having sent or received the message. Non-repudiation may be achieved through the use of technical methods.			N		HITSP C26 document October 15, 2007; HL7 Legal EHR-S Functional Profile IN 1.5 (Registration Release 1, June 1, 2007)		PC.48a

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PC 08.01	PC	AM	8. Manage Clinical Documentation	Documentation	The system shall (will) provide the ability to record the author, date and time of the in-progress note and the final note		N					PC.49a
PC 08.02	PC	AM	8. Manage Clinical Documentation	Documentation	The system shall provide the ability to save a note in progress prior to finalizing the note, and shall retain the author, date, time of the saving of a note whether still in progress or finalized. The author, date and time of each save shall be documented in an audit trail.		N					PC.50a
PC 08.03	PC	AM	8. Manage Clinical Documentation	Cosign	The system shall provide the ability to identify the identity of the cosigning author of a note and record the date and time of original author and identity of signature.		N			Existing AMB Criteria.		PC.53a
PC 08.04	PC	AM	8. Manage Clinical Documentation	Edit trail of addendums and corrections	The system shall provide the ability to addend and/or correct notes that have been finalized, and shall retain all original documentation. Nothing is deleted, and is all retained in audit trails and metadata.		N		No documentation is ever deleted, and it is all retained in edit trails and metadata. Definition of terms for the Privacy recommendation: Edit Trail - when edits are made to finalized documentation that are part of the patient record - these types of changes are tracked in the edit trail. Audit trail - refers to "behind the scenes" tracing of access which are Security criteria. The Privacy & Compliance EP recommendations for criteria are the original and addended note is part of the edit trail and metadata, but not part of the audit trail.	Existing AMB Criteria.		PC.54a
PC 08.05	PC	AM	8. Manage Clinical Documentation	Edit trail of addendums and corrections	The system shall provide the ability to identify the full content of a modified note, both the original content and the content resulting after any changes, corrections, clarifications, addenda, etc. to a finalized note including date/time/author identity		N		Modified to include 'including date/time/author identity.	Existing AMB Criteria.		PC.55a
PC 08.06	PC	AM	8. Manage Clinical Documentation	Edit trail of addendums and corrections	The system shall record and display the identity of the user who addended or corrected a note, as well as other attributes of the addenda or correction, such as the date and time of the change.		N			Existing AMB Criteria.		PC.56a
PC 08.07	PC	AM	8. Manage Clinical Documentation	Edit trail of addendums and corrections	The system shall have the capacity to retain all recorded data in the production data base or archive for the minimum required per law.		N			Existing AMB Criteria. Journal of the American Health Information Management Association (AHIMA), Mar-07 Connecting for Health 2006 California Medical Association - CMA Document #1160 Retention of Medical Records 2004; Federal False Claims Act;		PC.57a

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						2008 Certification	Roadmap 2009	Roadmap 2010 and Beyond				
PC 08.08	PC	AM	8. Manage Clinical Documentation	Retention and archiving	The system shall provide an administrative function allowing an administrator to set rules for data retention, automated archiving and data retrieval within minimum required by law.		N		Compliance Key: P = Previous Criteria M = Modified for Year N = New for Year O = Provisional	Existing AMB Criteria Lines 54-61 Journal of the American Health Information Management Association (AHIMA), Mar-07 Connecting for Health 2006 California Medical Association - CMA Document #1160 Retention of Medical Records 2004		PC.59a
PC 09.01	PC	AM	9. Manage Sharing of Documents	Standards-based specification for managing the sharing of documents	The system shall be able to support the standards identified and recommended by the Health Information Technology Standards Panel (HITSP) on its HITSP-TP13 Ver 1.0.1 document			N	Roadmapped to align with Health Information Technology Standards Panel	added from HITSP		NEW
PC 10.01	PC	FN	10. Nonrepudiation of Origin	Proof of the integrity and origin of documents in a high-assurance manner which can be verified by any party. This does not provide Nonrepudiation of Receipt.	The system shall support proof of the integrity and origin of documents in a high-assurance manner which can be verified by any party, thus being able to support the standards identified and recommended by the Health Information Technology Standards Panel		N		Roadmapped to align with Health Information Technology Standards Panel	Health Information Technology Standards Panel		PC.60a
PC 11.01	PC	FN	11. Patient Identity	Identity proofing	The system shall provide the ability to access demographic information needed for clinician ordering, verification and medication administration. When SSN is documented within the EHR the first 5 digits should be blind and only the last 4 digits available to use for patient identification.			N		1.01 AMB CCHIT Criteria; American Health Information Community (AHIC) Medication Management Use Case		PC.61a

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PC 12.01			12. Secure Communication	Secure Communication	<p>The Secured Communication Channel Transaction provides the mechanisms to ensure the authenticity, integrity, and confidentiality of Transactions, and the mutual trust between communicating parties. Its objectives include providing:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mutual node authentication to assure each node of the others' identity; <input type="checkbox"/> Transmission integrity to guard against improper information modification or destruction while in transit; and <input type="checkbox"/> Transmission confidentiality to ensure that information in transit is not disclosed to unauthorized individuals, entities, or processes <p>This Secured Communications Channel Transaction supports both application and machine credentials, and user machines (user nodes). Details of how a user authenticates to a node or application is beyond the scope of this construct. Practical examples of this Transaction are a secured communication channel between a Personal Health Record (PHR) system and an Electronic Health Record (EHR) system, or between an EHR system and a laboratory.</p>		N		Health Information Technology Standards Panel - The systems will allow the sharing of authentication and authenticity of the transaction			NEW
PC 13.01	PC	FN	13. Security	Patient and Roles	The system shall record within each audit record the following information when it is available: (1) date and time of the event; (2) the component of the system (e.g. software component, hardware component) where the event occurred; (3) type of event (including: data description and patient identifier when relevant); (4) subject identity (e.g. user identity); and (5) the outcome (success or failure) of the event.			N		CC SFR: FAU_GEN; SP800-53: AU-3 CONTENT OF AUDIT RECORDS, AU-10 NON-REPUDIATION; HIPAA: 164.312(b)		PC.68
PC 13.02	PC	FN	13. Security	Warning notice	The system, prior to a user login, shall display a (configurable) notice warning (e.g. "The system should only be accessed by authorized users").			N		CC 2.1 L.4 TOE access banners (FTA_TAB); CC 3.0 FIA_TIN.1 Advisory warning message		PC.70a
SC 01.01	SC	FN	1. Access Control	Security Access Control	The system shall enforce the most restrictive set of rights/privileges or accesses needed by users/groups (e.g. System Administration, Clerical, Nurse, Doctor, etc.), or processes acting on behalf of users, for the performance of specified tasks.	P				ISO 17799: 9.1.1.2.b; HIPAA: 164.312(a)(1)	5.13, 5.14, 5.20, 5.23	S1
SC 01.02	SC	FN	1. Access Control	Security Access Control	The system shall provide the ability for authorized administrators to assign restrictions or privileges to users/groups.	P				Canadian: Alberta 4.1.3 (EMR); CC SFR: FMT_MSA; SP800-53: AC-5 LEAST PRIVILEGE; HIPAA: 164.312(a)(1)	5.18	S2

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SC 01.03	SC	FN	1. Access Control	Security Access Control	The system must be able to associate permissions with a user using one or more of the following access controls: 1) user-based (access rights assigned to each user); 2) role-based (users are grouped and access rights assigned to these groups); or 3) context-based (role-based with additional access rights assigned or restricted based on the context of the transaction such as time-of-day, workstation-location, emergency-mode, etc.)	P				Canadian: Ontario 5.3.12.e (System Access Management); CC SFR: FDP_ACC, FMT_MSA; ASTM: E1985-98; SP800-53: AC-3 ACCESS AND INFORMATION FLOW CONTROL; HIPAA: 164.312(a)(1)	5.10, 5.13, 5.14, 5.18, 5.20, 5.23	S3
SC 01.04	SC	FN	1. Access Control	Security Access Control	The system shall support removal of a user's privileges without deleting the user from the system. The purpose of the criteria is to provide the ability to remove a user's privileges, but maintain a history of the user in the system.	P					5.39, 5.41, 5.42, 5.44, 5.46, 5.47	S4
SC 01.05	SC	FN	1. Access Control	Security: Access Control	If role-based access control (RBAC) is supported, the system shall be able to provide role based access control that is in compliance with the HL7 Permissions Catalog.			N		HL7 Permissions Catalog		S40
SC 01.06	SC	FN	1. Access Control	Security: Access Control	If role-based access control (RBAC) is supported, the system must be capable of operating within an RBAC infrastructure conforming to ANSI INCITS 359-2004, American National Standard for Information Technology – Role Based Access Control.			N		ANSI INCITS 359-2004, American National Standard for Information Technology - Role Based Access Control		S41
SC 02.01	SC	FN	2. Audit	Security Audit	The system shall allow an authorized administrator to enable or disable auditing for events or groups of related events to properly collect evidence of compliance with implementation-specific policies. Note: In response to a HIPAA-mandated risk analysis and management, there will be a variety of implementation-specific organizational policies and operational limits.		P		This criterion was provisional for 2007 and is being moved to 2009 Roadmap for revision based on an analysis of 2008 pilot test results and commission's recommendations on 4/15/2008.	CC SFR: FAU_SEL; HIPAA 164.312(b)		S11
SC 02.03	SC	FN	2. Audit	Security Audit	The system shall be able to detect security-relevant events that it mediates and generate audit records for them. At a minimum the events shall include: start/stop, user login/logout, session timeout, account lockout, patient record created/viewed/updated/deleted, scheduling, query, order, node-authentication failure, signature created/validated, PHI export (e.g. print), PHI import, and security administration events. Note: The system is only responsible for auditing security events that it mediates. A mediated event is an event that the system has some active role in allowing or causing to happen or has opportunity to detect. The system is not expected to create audit logs entries for security events that it does not mediate.	P				CC SFR: FAU_GEN; SP800-53: AU-2 AUDITABLE EVENTS; HIPAA: 164.312(b)	5.51	S5.2

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SC 02.04	SC	FN	2. Audit	Security Audit	The system shall record within each audit record the following information when it is available: (1) date and time of the event; (2) the component of the system (e.g. software component, hardware component) where the event occurred; (3) type of event (including: data description and patient identifier when relevant); (4) subject identity (e.g. user identity); and (5) the outcome (success or failure) of the event.	P			<div style="border: 1px solid black; padding: 5px; width: fit-content;"> Compliance Key: P = Previous Criteria M = Modified for Year N = New for Year O = Provisional </div>	CC SFR: FAU_GEN; SP800-53: AU-3 CONTENT OF AUDIT RECORDS, AU-10 NON-REPUDIATION; HIPAA: 164.312(b)	5.52	S6
SC 02.05	SC	FN	2. Audit	Security Audit	The system shall provide authorized administrators with the capability to read all audit information from the audit records in one of the following two ways: 1) The system shall provide the audit records in a manner suitable for the user to interpret the information. The system shall provide the capability to generate reports based on ranges of system date and time that audit records were collected. 2) The system shall be able to export logs into text format in such a manner as to allow correlation based on time (e.g. UTC synchronization).	P			Assignable to third party.	CC SFR: FAU_SAR; SP800-53: AU-7 AUDIT REDUCTION AND REPORT GENERATION; HIPAA: 164.312(b)	5.52, 7.14	S7
SC 02.06	SC	FN	2. Audit	Security Audit	The system shall be able to support time synchronization using NTP/SNTP, and use this synchronized time in all security records of time.	P			Assignable to third party.	CC SFR: FPT_STM; SP800-53: AU-8 TIME STAMPS	6.12, 7.18	S8.1
SC 02.07	SC	FN	2. Audit	Security Audit	The system shall have the ability to format for export recorded time stamps using UTC based on ISO 8601. Example: "1994-11-05T08:15:30-05:00" corresponds to November 5, 1994, 8:15:30 am, US Eastern Standard Time.	O			This criterion was provisional for 2007 and will continue to be provisional in 2008 due to a change made to test step based on 2008 pilot test results.	CC SFR: FPT_STM; SP800-53: AU-8 TIME STAMPS	5.53	S8.2
SC 02.08	SC	FN	2. Audit	Security Audit	The system shall prohibit all users read access to the audit records, except those users that have been granted explicit read-access. The system shall protect the stored audit records from unauthorized deletion. The system shall prevent modifications to the audit records.	P			This criterion is being changed to be an assignable criteria for 2008	CC SFR: FAU_SAR, FAU_STG; SP800-53: AU-9 PROTECTION OF AUDIT INFORMATION; HIPAA: 164.312(a)(1)	5.14, 5.20	S9
SC 03.01	SC	FN	3. Authentication	Security Authentication	The system shall authenticate the user before any access to Protected Resources (e.g. PHI) is allowed, including when not connected to a network e.g. mobile devices.	P			Assignable to third party.	Canadian: Alberta 1.1; CC SFR: FIA_UAU, FIA_UID; SP800-53: IA-2 USER IDENTIFICATION AND AUTHENTICATION; HIPAA: 164.312(d)	5.18, 5.22, 5.29, 5.34, 5.36, 5.41, 7.09	S12

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SC 03.02	SC	FN	3. Authentication	Security Authentication	When passwords are used, the system shall support password strength rules that allow for minimum number of characters, and inclusion of alpha-numeric complexity.	P			Assignable to third party.	Canadian: Alberta 7.3.12 (Security) Canadian Ontario 5.3.12.b (System Access Management); CC SFR: FIA_SOS, FIA_UAU, FIA_UID; ASTM: E1987-98; SP800-53: IA-2 USER IDENTIFICATION AND AUTHENTICATION (no strength of password); ISO 17799: 9.3.1.d; HIPAA: 164.	5.11, 5.26, 5.30, 7.05, 7.13	S13
SC 03.03	SC	FN	3. Authentication	Security Authentication	The system upon detection of inactivity of an interactive session shall prevent further viewing and access to the system by that session by terminating the session, or by initiating a session lock that remains in effect until the user reestablishes access using appropriate identification and authentication procedures. The inactivity timeout shall be configurable.	P			Assignable to third party.	Canadian: Alberta 7.3.14 (Security) Canadian Ontario 5.6.12.a (Workstation Security); CC SFR: FTA_SSL, FMT_SAE; SP800-53: AC-11 SESSION LOCK; HIPAA: 164.312(a)(1)	5.25, 5.28, 5.29, 7.12	S14
SC 03.04	SC	FN	3. Authentication	Security Authentication	The system shall enforce a limit of (configurable) consecutive invalid access attempts by a user. The system shall protect against further, possibly malicious, user authentication attempts using an appropriate mechanism (e.g. locks the account/node until released by an administrator, locks the account/node for a configurable time period, or delays the next login prompt according to a configurable delay algorithm).	P			Assignable to third party.	Canadian: Ontario 5.3.12.c (System Access Management); CC SFR: FIA_AFL, FMT_SAE; SP800-53: AC-6 UNSUCCESSFUL LOGIN ATTEMPTS, AC-11 SESSION LOCK ; ISO 17799: 9.3.1.e, 9.5.2.e; HIPAA: 164.312(a)(1)	5.12, 5.32, 5.33, 5.34, 7.06	S15
SC 03.05	SC	FN	3. Authentication	Security Authentication	When passwords are used, the system shall provide an administrative function that resets passwords.	P			Assignable to third party.	CC SFR: FMT_MTD; ISO 17799: 9.2.3.b, (9.3.1.f); HIPAA: 164.312(d)	5.50, 7.15	S16.1
SC 03.06	SC	FN	3. Authentication	Security Authentication	When passwords are used, user accounts that have been reset by an administrator shall require the user to change the password at next successful logon.	P			Assignable to third party.	CC SFR: FMT_MTD; ISO 17799: 9.2.3.b, (9.3.1.f); HIPAA: 164.312(d)	5.55, 7.16	S16.2
SC 03.07	SC	FN	3. Authentication	Security Authentication	The system shall provide only limited feedback information to the user during the authentication.	P			Assignable to third party.	CC SFR: FIA_UAU; SP800-53: IA-6 AUTHENTICATOR FEEDBACK; HIPAA: 164.312(d)	5.17, 5.19, 5.42, 7.08	S17
SC 03.08	SC	FN	3. Authentication	Security Authentication	The system shall support case-insensitive usernames that contain typeable alpha-numeric characters in support of ISO-646/ECMA-6 (aka US ASCII).	P			Assignable to third party.	CC SFR: FMT_MTD	5.22, 7.11	S18

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SC 03.09	SC	FN	3. Authentication	Security Authentication	When passwords are used, the system shall allow an authenticated user to change their password consistent with password strength rules (SC 03.02).	P			Assignable to third party.	CC SFR: FMT_MTD	5.26, 5.30, 7.13	S19
SC 03.10	SC	FN	3. Authentication	Security Authentication	When passwords are used, the system shall support case-sensitive passwords that contain typeable alphanumeric characters in support of ISO-646/ECMA-6 (aka US ASCII).	P			Assignable to third party.	Canadian: Ontario 5.3.12 (b); SP 800-63	5.16, 5.18, 5.22, 7.07	S20
SC 03.11	SC	FN	3. Authentication	Security Authentication	When passwords are used, the system shall use either standards-based encryption, e.g., 3DES, AES, or standards-based hashing, e.g., SHA1 to store or transport passwords.	M				Canadian: Ontario 5.3.12.a (System Access Management); CC SFR: FCS_CKM; SP800-53: SC-12 CRYPTOGRAPHIC KEY ESTABLISHMENT AND MANAGEMENT; HIPAA: 164.312(e)(1)	6.17, 6.18, 7.23, 7.24	S21
SC 03.12	SC	FN	3. Authentication	Security Authentication	When passwords are used, the system shall prevent the reuse of passwords previously used within a specific (configurable) timeframe (i.e., within the last X days, etc. - e.g. "last 180 days"), or shall prevent the reuse of a certain (configurable) number of the most recently used passwords (e.g. "last 5 passwords").	P			Assignable to third party.	CC SFR: FMT_MTD; ISO 17799 9.5.4.f; HIPAA 164.312(d)	6.01, 7.25	S22
SC 03.13	SC	FN	3. Authentication	Security Authentication	The system shall support two-factor authentication in alignment with NIST 800-63 Level 3 Authentication. Note: The standards in this area are still evolving.			M		CC SFR: FIA_UAU; SP800-53: IA-2/AC-19, OMB M-06-16		S31
SC 04.01	SC	FN	4. Documentation	Reliability: Documentation	The system shall include documentation that describes the patch (hot-fix) handling process the vendor will use for EHR, operating system and underlying tools (e.g. a specific web site for notification of new patches, an approved patch list, special instructions for installation, and post-installation test).	P				CC SFR: AGD_ADM	6.07	R10
SC 04.02	SC	FN	4. Documentation	Reliability: Documentation	The system shall include documentation that explains system error or performance messages to users and administrators, with the actions required.	P				CC SFR: AGD_ADM	6.08	R11
SC 04.03	SC	FN	4. Documentation	Reliability: Documentation	The system shall include documentation of product capacities (e.g. number of users, number of transactions per second, number of records, network load, etc.) and the baseline representative configurations assumed for these capacities (e.g. number or type of processors, server/workstation configuration and network capacity, etc).	P				CC SFR: AGD_ADM; SP800-53 CM-2	6.09	R12
SC 04.04	SC	FN	4. Documentation	Reliability: Documentation	The system shall include documented procedures for product installation, start-up and/or connection.	P				CC SFR: ADO_IGS	6.06	R13

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SC 04.05	SC	FN	4. Documentation	Reliability: Documentation	The system shall include documentation of the minimal privileges necessary for each service and protocol necessary to provide EHR functionality and/or serviceability.	P				SP800-53 AC-5	6.05	R16
SC 04.06	SC	FN	4. Documentation	Reliability: Documentation	The system shall include documentation available to the customer stating whether or not there are known issues or conflicts with security services in at least the following service areas: antivirus, intrusion detection, malware eradication, host-based firewall and the resolution of that conflict (e.g. most systems should note that full virus scanning should be done outside of peak usage times and should exclude the databases.).	P				Canadian: Alberta 7.3.17 (Security); CC SFR: FPT_TST CC SFR: AGD_ADM; SP800-53 SI-3 MALICIOUS CODE PROTECTION	6.03	R4
SC 04.07	SC	FN	4. Documentation	Reliability: Documentation	If the system includes hardware, the system shall include documentation that covers the expected physical environment necessary for proper secure and reliable operation of the system including: electrical, HVAC, sterilization, and work area.	P				CC SFR: AGD_ADM	6.04	R5
SC 04.08	SC	FN	4. Documentation	Reliability: Documentation	The system shall include documentation that itemizes the services (e.g. PHP, web services) and network protocols/ports (e.g. HL-7, HTTP, FTP) that are necessary for proper operation and servicing of the system, including justification of the need for that service and protocol. This information may be used by the healthcare facility to properly configure their network defenses (firewalls and routers).	P				CC SFR: AGD_ADM; SP 800-53 AC-5 CM-6; SP 800-70; HIPAA 164.312(a)(1)	6.05	R7
SC 04.09	SC	FN	4. Documentation	Reliability: Documentation	The system shall include documentation that describes the steps needed to confirm that the system installation was properly completed and that the system is operational.	P				CC SFR: AGD_ADM	6.06	R9
SC 04.10	SC	FN	4. Documentation	Security Documentation	The system shall include documentation available to the customer that provides guidelines for configuration and use of the EHR security controls necessary to support secure and reliable operation of the system, including but not limited to: creation, modification, and deactivation of user accounts, management of roles, reset of passwords, configuration of password constraints, and audit logs.	P			Assignable to third party.	CC SFR: AGD_ADM	5.04, 5.09, 6.02, 7.04	S23
SC 05.01	SC	FN	5. Technical Services	Reliability: Technical Services	The software used to install and update the system, independent of the mode or method of conveyance, shall be certified free of malevolent software ("malware"). Vendor may self-certify compliance with this standard through procedures that make use of commercial malware scanning software.	P				CC SFR: ADO_DEL	6.11	R14
SC 05.02	SC	FN	5. Technical Services	Reliability: Technical Services	The system shall be configurable to prevent corruption or loss of data already accepted into the system in the event of a system failure (e.g. integrating with a UPS, etc.).	P			Assignable to third party.	CC SFR: FPT_RCV	6.10, 7.17	R17

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SC 06.01	SC	FN	6. Technical Services	Security Technical Services	The system shall support protection of confidentiality of all Protected Health Information (PHI) delivered over the Internet or other known open networks via encryption using triple-DES (3DES) or the Advanced Encryption Standard (AES) and an open protocol such as TLS, SSL, IPSec, XML encryptions, or S/MIME or their successors.	P			Assignable to third party.	Canadian: Alberta 7.4.6.2 & 8.4.6.2 (Technical); CC SFR: FCS_COP; FIPS 140-2; SP800-53: SC-13 CRYPTOGRAPHIC OPERATIONS; HIPAA: 164.312(e)(1); HITSP T17,	6.13, 7.19	S24
SC 06.02	SC	FN	6. Technical Services	Security Technical Services	When passwords are used, the system shall not display passwords while being entered.	P			Assignable to third party.	CC SFR: FPT_ITC; ISO 17799 9.2.3; HIPAA 164.312(a)(1)	5.19, 7.10	S26
SC 06.03	SC	FN	6. Technical Services	Security Technical Services	For systems that provide access to PHI through a web browser interface (i.e. HTML over HTTP) shall include the capability to encrypt the data communicated over the network via SSL (HTML over HTTPS). Note: Web browser interfaces are often used beyond the perimeter of the protected enterprise network	P			Assignable to third party.	CC SFR: AGD_ADM	6.16, 7.22	S27
SC 06.04	SC	FN	6. Technical Services	Security Technical Services	The system shall support protection of integrity of all Protected Health Information (PHI) delivered over the Internet or other known open networks via SHA1 hashing and an open protocol such as TLS, SSL, IPSec, XML digital signature, or S/MIME or their successors.	P			Assignable to third party.	CC SFR: FPT_RCV; FIPS 140-2; SP800-53: SC-13 CRYPTOGRAPHIC OPERATIONS; HIPAA: 164.312(e)(1); HITSP T17	6.14, 7.20	S28
SC 06.05	SC	FN	6. Technical Services	Security Technical Services	The system shall support ensuring the authenticity of remote nodes (mutual node authentication) when communicating Protected Health Information (PHI) over the Internet or other known open networks using an open protocol (e.g. TLS, SSL, IPSec, XML sig, S/MIME).	P			Assignable to third party.	CC SFR: FPT_RCV; HITSP T17	6.15, 7.21	S29
SC 06.07	SC	FN	6. Technical Services	Security: Technical Services	The system, prior to a user login, shall display a (configurable) notice warning (e.g. "The system should only be accessed by authorized users").		P			CC 2.1 L.4 TOE access banners (FTA_TAB); CC 3.0 FIA_TIN.1 Advisory warning message		S33
SC 07.01	SC	FN	7. Inter-Domain	Security: Inter Domain	The system shall be able to communicate identity information across domains and web services using standards based user authentication and access control.			N		HITSP/C19, ANSI INCITS 359-2004, American National Standard for Information Technology - Role Based Access Control		S38
SC 07.02	SC	FN	7. Inter-Domain	Security: Inter Domain	When the system uses HITSP TP13 (IHE XDS) as a Document Consumer, the system shall be able to use the TP13 "Document Integrity" option. This may be a configurable parameter or may be enabled at all times			N		HITSP TP13 (IHE XDS)		S39
SC 08.01	SC	FN	8. Backup/Recovery	Reliability: Backup and Recovery	The system shall be able to generate a backup copy of the application data, security credentials, and log/audit files.	P			Assignable to third party.	Canadian: Alberta 7.3.16 (Security); CC SFR: FDP_ROL, FPT_RCV; HIPAA: 164.310(d)(1)	5.01, 7.01	R1

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SC 08.02	SC	FN	8. Backup/Recovery	Reliability: Backup and Recovery	The system restore functionality shall result in a fully operational and secure state. This state shall include the restoration of the application data, security credentials, and log/audit files to their previous state.	P			Assignable to third party.	Canadian: Alberta 7.3.18.9 (Security); CC SFR: FAU_GEN; SP800-53: AU-2 AUDITABLE EVENTS; HIPAA: 164.310(d)(1)	5.06, 5.08, 7.03	R2
SC 08.03	SC	FN	8. Backup/Recovery	Reliability: Backup and Recovery	If the system claims to be available 24x7 then the system shall have ability to run a backup concurrently with the operation of the application.	P			Assignable to third party.	Canadian: Alberta 7.4.2.5 (Technica+D11); CC SFR: FDP_ROL; HIPAA: 164.310(d)(1)	5.02, 7.02	R3