



**2011 LTPAC Criteria and SN and HH Add-ons**  
**First Draft Certification Criteria**  
 For Public Comment - December 14, 2009

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**N** = New for LTPAC  
**NS** = New for Skilled Nursing Add-on  
**NH** = New for Home Health Add-on  
**O** = Optional for LTPAC  
**R** = Roadmap for LTPAC  
**RS** = Roadmap for Skilled Nursing  
**RH** = Roadmap for Home Health

To select only criteria for Skilled Nursing or Home Health Add-On, filter column F, G and H to only include rows with value=NS and RS or value=NH and RH

UNIQUE ID	Criteria #	Category	Criteria	Year introduced or last modified	2011 Certification	2013 Roadmap	2015+ Roadmap	Comments	Criteria Reference
Draft1.501	LT 01.01	Patient record and demographics	The system shall provide the ability to create a single patient record for each patient.	2011	N				AM 01.01, DC.1.1.1
Draft1.502	LT 01.02	Patient record and demographics	The system shall provide the ability to associate (store and link) key identifier information (e.g., system ID, medical record number) with each patient record.	2011	N			Key identifier information must be unique to the patient record but may take any system defined internal or external form.	AM 1.02, DC.1.1.1
Draft1.503	LT 01.03	Patient record and demographics	The system shall provide the ability to store more than one identifier for each patient record.	2011	N			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.	AM 01.03, DC.1.1.1
Draft1.504	LT 01.04	Patient record and demographics	The system shall provide the ability to merge patient information from two patient records into a single patient record.				R	If a duplicate chart is created, information could be merged into one chart.  Does not imply an unmerge capability. The intent is to merge information for a single patient; this would include discrete data elements from both patient records.	AM 01.05, DC.1.1.1
Draft1.505	LT 01.05	Patient record and demographics	The system shall provide the ability to include demographic information in reports.	2011	N			This includes using demographics to generate reports and also allows demographics to be gathered into a report. See also "Report generation" functionality.	AM 02.01, DC.1.1.2
Draft1.506	LT 01.06	Patient record and demographics	The system shall provide the ability to maintain and make available historic information for demographic data including prior names, addresses, phone numbers and e-mail addresses.	2011	N			Providers need this for look up and contact purposes, e.g., when attempting to locate a patient or family member for clinical communications. This is useful for identity management.	AM 02.02, DC.1.1.2
Draft1.507	LT 01.07	Patient record and demographics	The system shall provide the ability to associate at least two or more full names with a single patient record.				R	Intended to address situations where a patient is known by more than one name.	AM 02.03.01
Draft1.508	LT 01.08	Patient record and demographics	The system shall provide the ability to modify demographic information about the patient.	2011	N				AM 02.04, DC.1.1.2
Draft1.509	LT 01.09	Patient record and demographics	The system shall provide the ability to retrieve a patient record by any of the full names associated with it. If a patient record has more than one name associated with it there shall be an indication to the user to that effect.				R	Intent is that the multiple names that are added pursuant to AM 02.03a can be used to retrieve the record.	AM 02.03.02
Draft1.510	LT 01.10	Patient record and demographics	The system shall provide the ability to retrieve a patient record by any of the prior names associated with it. If a patient record is retrieved by a prior name there should be an indication to the user to that effect.				R		AM 02.03.03
Draft1.511	LT 01.11	Patient record and demographics	The system shall provide the ability to store demographic information in the patient medical record in separate discrete data fields, such that data extraction tools can retrieve these data.	2011	N				AM 02.05, DC.1.1.2
Draft1.512	LT 01.12	Patient record and demographics	The system shall provide the ability to access and display demographic information such as name, date of birth, and gender needed for patient care functions as discrete data elements within the patient record.	2011	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.	FN 01.01.01
Draft1.513	LT 01.13	Patient record and demographics	The system shall provide the ability to record a suffix to the patient's name (e.g., Sr., Jr., III, etc.)				R		FN 01.01.02

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Draft1.514	LT 01.14	Patient record and demographics	The system shall provide the ability to capture and maintain demographic information as discrete data elements as part of the patient record.	2011	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. This criterion will be replaced by FN 01.01.01 in 10.	FN 02.01
Draft1.515	LT 01.15	Patient record and demographics	The system shall provide the ability to query for a patient by more than one form of identification.	2011	N			For example, patient last name, medical record number, account number, or phone number.	FN 02.01
Draft1.516	LT 01.16	Patient record and demographics	The system shall provide the ability to designate the place of service for a given encounter: permanent or date-sensitive temporary addresses.	2011	NH				Source is WG discussion.
Draft1.517	LT 01.17	Patient record and demographics	The system shall provide the ability to keep multiple, date-sensitive, temporary patient addresses and phone numbers in addition to listing a patient's permanent address.	2011	NH				Source is WG discussion.
Draft1.518	LT 01.18	Patient record and demographics	The system shall provide the ability to store directions to a patient's home as free-text.	2011	NH				Source is WG discussion.
Draft1.519	LT 01.19	Patient record and demographics	The system shall provide the ability to alert a user if registration is incomplete.			R			Source is WG discussion.
Draft1.520	LT 01.20	Patient record and demographics	The system shall provide the ability to capture, present, maintain, and make available for clinical decisions <u>patient</u> preferences such as language, religion, and spiritual and cultural practices.	2011	N			This could be done in free text now, should be discrete data in the future.	DC.1.3.1
Draft1.521	LT 01.21	Patient record and demographics	The system shall provide the ability to capture, present, maintain and make available for clinical decisions <u>family</u> preferences such as language, religion, and spiritual and cultural practices.	2011	N			This could be done in free text now, should be discrete data in the future.	DC.1.3.1
Draft1.522	LT 01.22	Patient record and demographics	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.	2011	N			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.	FN 03.01, S.3.4
Draft1.523	LT 01.23	Patient record and demographics	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.	2011	N				FN 03.02, S.3.4
Draft1.524	LT 02.01	Patient List	The system shall provide for the ability to identify patients by status (e.g., active, admitted patients or inactive, discharged patients).	2011	N				IP 03.01
Draft1.525	LT 02.02	Patient List	The system shall provide the ability to search all patient records and identify individual patients with specific problems/diagnoses.	2011	N				IP 04.11
Draft1.526	LT 02.03	Patient List	The system shall provide the ability to identify all patients on a specific medication.	2011	N				IP 16.12
Draft1.527	LT 03.01	Problem list	The system shall provide the ability to capture, maintain, and display, as discrete data elements, all problems/diagnoses associated with a patient.	2011	N			Would include current/active and past/resolved problems.	FN 04.02
Draft1.528	LT 03.02	Problem list	The system shall provide the ability to maintain the onset date of a problem/diagnosis.	2011	N			It is a vendor design decision whether to require complete date or free text of approximate date.	AM 03.03, DC.1.4.3
Draft1.529	LT 03.03	Problem list	The system shall provide the ability to maintain the resolution date of the problem/diagnosis.	2011	N				AM 03.04
Draft1.530	LT 03.04	Problem list	The system shall provide the ability to record the chronicity (chronic, acute/self-limiting, etc.) of a problem/diagnosis.			R			AM 03.05, DC.1.4.3
Draft1.531	LT 03.05	Problem list	The system shall provide the ability to record and display the user ID and date of all updates to the problem/diagnosis list.	2011	N				AM 03.06, DC.1.4.3
Draft1.532	LT 03.07	Problem list	The system shall provide the ability to associate orders and medications with one or more codified problems/diagnoses.	2011	N			The expectation is to associate multiple diagnoses.	AM 03.07, AM 03.08.01, DC.1.4.3
Draft1.533	LT 03.08	Problem list	The system shall provide the ability to associate notes with one or more codified problems/diagnoses.			R			AM 03.08.02

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Draft1.534	LT 03.09	Problem list	The system shall provide the ability to maintain a coded list of problems/diagnoses.	2011	N			For example: ICD-9 CM, ICD-10 CM, SNOMED-CT, DSM-IV. The Work Group will not specify which code set(s) are to be employed.	AM 03.09, DC.1.4.3
Draft1.535	LT 03.10	Problem list	The system shall provide the ability to display different views of the problem/diagnosis list based upon the status of the problem.	2011	N			For example, active, all, or resolved, or charted in error.	FN 04.06
Draft1.536	LT 03.11	Problem list	The system shall provide the ability to capture, maintain, and display free text comments associated with the problem/diagnosis.	2011	N				FN 04.01
Draft1.537	LT 03.12	Problem list	The system shall provide the ability to print a problem/diagnosis list.	2011	N			A screen print is not the intention of this criterion.	FN 04.04
Draft1.538	LT 03.13	Problem list	The system shall provide the ability to prevent diagnoses from being viewed, printed, or accessed by users without appropriate privileges.			R		For example, prevent viewing by non-clinicians.	IP 04.04, Regulatory requirements
Draft1.539	LT 03.14	Problem list	When the display of the problem list exceeds the current screen or printed page, the system shall indicate that the list continues.	2011	N			Use of a scroll bar is acceptable to indicate that the list continues.	IP 04.05
Draft1.540	LT 03.15	Problem list	The system shall provide the ability to modify documentation entered in error, maintaining a record of the original entry, identification of the clinician correcting the error and the date and time corrected.	2011	N				IP 04.06, HL7 9.4.5 - 9.4.11
Draft1.541	LT 04.01	Medication list	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.	2011	N				Source is WG discussion.
Draft1.542	LT 04.02	Medication list	The system shall provide the ability to maintain medication ordering dates.	2011	N				AM 04.03, DC.1.4.2
Draft1.543	LT 04.03	Medication list	The system shall provide the ability to maintain other dates associated with medications including start, modify, renewal and end dates as applicable.	2011	N				AM 04.04, DC.1.4.2
Draft1.544	LT 04.04	Medication list	The system shall provide the ability to display medication history for the patient.	2011	N				AM 04.05, DC.1.4.2
Draft1.545	LT 04.05	Medication list	The system shall provide the ability to capture medications entered by authorized users other than the prescriber.	2011	N			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.	AM 04.06, DC.1.4.2
Draft1.546	LT 04.06	Medication list	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.	2011	N				AM 04.07, DC.1.4.2
Draft1.547	LT 04.07	Medication list	The system shall include standard medication codes associated with each medication in the list for medications in the vendor-provided medication database.			R		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.	AM 04.08, DC.1.4.2
Draft1.548	LT 04.08	Medication list	The system shall provide the ability to enter uncoded or free text medications when medications are not in the vendor-provided medication database or information is insufficient to completely identify the medication.	2011	N			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).	AM 04.09
Draft1.549	LT 04.09	Medication list	The system shall provide the ability to enter or further specify in a discrete field that the patient takes no medications.	2011	N				AM 04.10
Draft1.550	LT 04.10	Medication list	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.	2011	N			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.	AM 04.11
Draft1.551	LT 04.11	Medication list	The system shall provide the ability to indicate that a prescription's specified stop or end date has passed, or automatically exclude from the display of current medications a prescription whose specified stop or end date has passed.	2011	N				AM 04.12

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Draft1.552	LT 04.12	Medication list	The system shall provide the ability to update and display a patient-specific medication list based on current medication orders or prescriptions.	2011	N				FN 06.01, DC.1.4.2
Draft1.553	LT 04.13	Medication list	The system shall provide the ability to display a view that includes only current medications.	2011	N				FN 06.02
Draft1.554	LT 04.14	Medication list	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.	2011	N				FN 06.03
Draft1.555	LT 04.15	Medication list	The system shall provide the ability to print a current medication list.	2011	N				FN 06.04, DC.1.4.2
Draft1.556	LT 04.16	Medication list	The system shall provide the ability to display that the patient takes no medications.	2011	N				FN 06.05
Draft1.557	LT 04.17	Medication list	The system shall provide the ability to capture maintain and display, as discrete data elements, all current medications including over-the-counter and complementary medications such as vitamins, herbs, and supplements.	2011	N				FN 06.06, DC.1.4.2
Draft1.558	LT 04.18	Medication list	When the display of the medication list exceeds the current screen or printed page, the system shall indicate that the list continues.	2011	N			For example, Page one of two, End of report.	IP 06.01
Draft1.559	LT 04.19	Medication List	The system shall provide the ability to record and display the reason or indication for the medication when recording historical or home medications.	2011	N			Does not require coded data, may be unknown or free text comments.	IP 06.07
Draft1.560	LT 04.20	Medication List	The system shall provide the ability to sort and filter the medication list.	2011	N			Filters could include, all medications and active medications. Sorting could include by order date or drug name.	IP 06.11
Draft1.561	LT 04.21	Medication List	The system shall provide the ability to capture and display the patient's preferred pharmacy or pharmacies.	2011	N				Source is WG discussion.
Draft1.562	LT 04.22	Medication List	The system shall provide the ability to display pharmacies that are associated with medications within patient record.			R		This is medication by medication basis.	Source is WG discussion.
Draft1.563	LT 05.01	Allergy and adverse reaction list	The system shall provide the ability to capture store and display lists of medications and other agents to which the patient has had an allergic or other adverse reaction in a standard coded form.			R		Pending standard codes for allergens.	AM 05.01
Draft1.564	LT 05.02	Allergy and adverse reaction list	The system shall provide the ability to modify or inactivate an item on the allergy and adverse reaction list.	2011	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. Could include changing the type of reaction for a particular allergy.	FN 05.01
Draft1.565	LT 05.03	Allergy and adverse reaction list	The system shall provide the ability to display information which has been inactivated or removed from the allergy and adverse reaction list.	2011	N				AM 05.03, DC.1.4.1
Draft1.566	LT 05.04	Allergy and adverse reaction list	The system shall provide the ability to distinguish between an allergy and an intolerance as discrete data.			R			AM 05.04
Draft1.567	LT 05.05	Allergy and adverse reaction list	The system shall provide the ability to specify the type of allergic or adverse reaction in a discrete data field.	2011	N				FN 05.04
Draft1.568	LT 05.06	Allergy and adverse reaction list	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.	2011	N			Attributes include the name of the allergen and the action (added, modified, inactivated or removed).	FN 05.05

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Draft1.569	LT 05.07	Allergy and adverse reaction list	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.			R			FN 05.07
Draft1.570	LT 05.08	Allergy and adverse reaction list	The system shall provide the ability to explicitly indicate in a discrete field that a patient has no known drug allergies or adverse reactions.	2011	N				FN 05.09
Draft1.571	LT 05.09	Allergy and adverse reaction list	The system shall provide the ability to display the allergy list, including date of entry.	2011	N			It must be possible for a user to view the date of entry for any allergy on the allergy list, but it is acceptable if that is viewed on another screen, e.g. a 'details' screen.	FN 05.12
Draft1.572	LT 05.10	Allergy and adverse reaction list	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.	2011	N				FN 05.13
Draft1.573	LT 05.11	Allergy and adverse reaction list	The system shall provide the ability to capture the severity of an allergic or adverse reaction.			R			IP 05.02, DC 1.4.1
Draft1.574	LT 05.12	Allergy and adverse reaction list	The system shall provide the ability to require the documentation of patient allergies (inclusive of using such terms as Unknown or Unable to Assess) before completion of the medication order.	2011	N				IP 05.04
Draft1.575	LT 05.13	Allergy and adverse reaction list	When the display of the allergy list exceeds the current screen or printed page, the system shall indicate that the list continues.	2011	N			Use of a scroll bar is acceptable to indicate that the list continues.	IP 05.08
Draft1.576	LT 05.14	Allergy and adverse reaction list	The system shall provide the configurable ability to enter free text allergies and display them in a manner that distinguishes them from coded allergy entries.	2011	N				IP 05.11
Draft1.577	LT 05.15	Allergy and adverse reaction list	The system shall provide the ability to indicate that interaction checking will not occur against free text allergies.	2011	N			The use of a field "other" with associated free text is acceptable.	IP 05.12
Draft1.578	LT 06.01	Patient history	The system shall provide the ability to capture, store, display, and manage patient history.	2011	N			Examples include past medical/surgical problems, diagnoses, procedures, family history, social history, environmental history.	AM 06.01, DC.1.2
Draft1.579	LT 06.02	Patient history	The system shall provide the ability to capture structured data in the patient history.			R		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.	AM 06.02, DC.1.2
Draft1.580	LT 06.03	Patient history	The system shall provide the ability to capture and display functional status.	2011	N			Standards should be appropriate to the care setting. Examples are MDS and OASIS. Free text is acceptable now and in the future discrete data will be required.	Source is WG discussion.
Draft1.581	LT 06.04	Patient history	The system shall provide the ability to update a patient history by modifying, adding, or removing items from the patient history as appropriate.	2011	N			Requirement not predicated on the capture of structured data.	AM 06.03, DC.1.2
Draft1.582	LT 06.05	Patient history	The system shall provide the ability to capture and display 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.	2011	N			Requirement not predicated on the capture of structured data.	AM 06.04, DC.1.2
Draft1.583	LT 06.06	Patient history	The system shall provide the ability to capture history collected from outside sources.	2011	N			This could include data from a personal health record, online patient histories, and information from pharmacy benefit management organizations. Please see interoperability criteria (IO-AM 11.xx) for specific requirements for electronic importation.	AM 06.05, DC.1.2
Draft1.584	LT 06.07	Patient history	The system shall provide the ability to capture patient history in a standard coded form.			R		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.	AM 06.06, DC.1.2

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Draft1.585	LT 07.01	Patient views	The system shall provide the ability to create and display a summary list for each patient that includes, at a minimum, the active problem/diagnosis list, current medication list, medication allergies, and adverse reactions.	2011	N			Health record summary is at the patient level as opposed to at the level of an individual visit or episode of care.	AM 07.01, DC.1.1.4
Draft1.586	LT 07.02	Patient views	The system shall provide the ability to provide filtered displays of encounters based on encounter characteristics, including date of service, and encounter provider.	2011	NH			Encounter is any visit by a clinician or home health aide.	S.3.1
Draft1.587	LT 07.03	Patient views	The system shall provide the ability to provide filtered displays based on encounter characteristics (e.g., diagnosis).	2011	NH				Source is WG discussion.
Draft1.588	LT 08.01	Clinical documents and notes	The system shall provide the ability to create clinical documentation or notes (henceforth "documentation").	2011	N				AM 08.01, DC.1.9.1
Draft1.589	LT 08.02	Clinical documents and notes	The system shall provide the ability to display documentation.	2011	N				AM 08.02, DC.1.9.1
Draft1.590	LT 08.03	Clinical documents and notes	The system shall provide the ability to save a note in progress prior to finalizing the note.	2011	N				AM 08.03, DC.1.9.1
Draft1.591	LT 08.04	Clinical documents and notes	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.	2011	N			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.	AM 08.04, DC.1.9.1
Draft1.592	LT 08.05	Clinical documents and notes	The system shall provide the ability to record the identity of the user finalizing each note and the date and time of finalization.	2011	N			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.	AM 08.05, DC.1.9.1
Draft1.593	LT 08.06	Clinical documents and notes	The system shall provide the ability to cosign a note and record the date and time of signature.				R	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.	AM 08.06
Draft1.594	LT 08.07	Clinical documents and notes	The system shall provide the ability to addend and/or correct notes that have been finalized.	2011	N			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.	AM 08.07, DC.1.9.1

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Draft1.595	LT 08.08	Clinical documents and notes	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.	2011	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. The intent of this criterion is to specify the information stored after finalization of a note; other criteria specify requirements prior to finalization.	Source is WG discussion.
Draft1.596	LT 08.09	Clinical documents and notes	The system shall provide the ability to record and display the identity of the user who added or corrected a note and the date and time of the change.	2011	N			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.	AM 08.09, DC.1.9.1
Draft1.597	LT 08.10	Clinical documents and notes	The system shall provide the ability to enter free text notes.	2011	N				AM 08.10, DC.1.9.1
Draft1.598	LT 08.11	Clinical documents and notes	The system shall provide the ability to filter, search, or order notes by the provider who finalized the note.	2011	N				AM 08.11, DC.1.9.1
Draft1.599	LT 08.12	Clinical documents and notes	The system shall provide the ability to filter, search or order notes by associated diagnosis within a patient record.				R	This is intended to be the coded diagnosis and not free text in the body of a note.	AM 08.12, DC.1.9.1
Draft1.600	LT 08.13	Clinical documents and notes	The system shall provide the ability to document multidisciplinary care or case conference including the participants, their discipline, and their role in the conference.	2011	N			This could be achieved by a free text note but must be categorized as a case conference note that is flagged in some manner to distinguish it from other note types. Documentation of physical attendance in the conference needs to be determined and is not necessarily addressed in this criteria.	Source is WG discussion.
Draft1.601	LT 08.14	Clinical documents and notes	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.				R	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.	AM 08.18, DC.1.9.1
Draft1.602	LT 08.15	Clinical documents and notes	The system shall provide templates for inputting data in a structured format as part of clinical documentation.	2011	N			Templates may include any patient encounter note documentation tool that provide a pre-set collection of clinical findings or fields, including macros driven by speech recognition technology, branching logic.  This list is not necessarily all inclusive of all the technology that may arrive in future.	AM 08.19, DC.1.9.1
Draft1.603	LT 08.16	Clinical documents and notes	The system shall provide the ability to customize clinical templates.	2011	N			Customization at the level of clinical content is satisfactory.	AM 08.20, DC.1.9.1
Draft1.604	LT 08.17	Clinical documents and notes	The system shall be provide the ability to record comments by the patient or the patient's representative regarding the accuracy or veracity of information in the patient record (henceforth 'patient annotations').	2011	N			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.	AM 08.21
Draft1.605	LT 08.18	Clinical documents and notes	The system shall provide the ability to display patient annotations in a manner which distinguishes them from other content in the system.	2011	N			A patient annotation in free-text or scanned-document form as described in AM 08.18, 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.	AM 08.22
Draft1.606	LT 08.19	Clinical documents and notes	The system shall provide the ability to capture clinical data elements as discrete data.	2011	N			For example, quantitative tobacco consumption, peak expiratory flow rate, size of lesions, severity of pain, etc.	AM 08.16, DC.1.9.1

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Draft1.607	LT 08.20	Clinical documents and notes	The system shall provide the ability to capture patient vital signs, including blood pressure, heart rate, respiratory rate, height, and weight, and level of consciousness as discrete data.	2011	N			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.	AM 08.13, DC.1.9.1
Draft1.608	LT 08.21	Clinical documents and notes	The system shall provide the ability to indicate to the user when a vital sign measurement falls outside a preset normal range as set by authorized users.	2011	N			Normal range shall be set at system level as opposed to individual patient level.  At a minimum, this must be possible for the following vital signs: systolic and diastolic blood pressures, heart rate, temperature, and respiratory rate.	AM 08.15
Draft1.609	LT 08.22	Clinical documents and notes	The system shall provide the ability to capture and display temperature, weight and height in both metric and English units.	2011	N			The criterion requires that the system be able to display both; it does not require that both are able to display on the same screen at the same time. The data should be capable of being displayed in the form in which is was entered.	AM 08.14
Draft1.610	LT 08.23	Clinical documents and notes	The system shall provide the ability to graph height and weight over time.			R			AM 08.24
Draft1.611	LT 08.24	Clinical documents and notes	The system shall provide the ability to calculate and display body mass index (BMI).			R			AM 08.25
Draft1.612	LT 08.25	Clinical documents and notes	The system shall provide the ability to document 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.	2011	N			This does not preclude entry via new technologies.	AM 31.02, S.3.1
Draft1.613	LT 09.01	External clinical documents	The system shall provide the ability to capture and store external documents.	2011	N			Scanned documents are sufficient; structured data will be expected in the future. This covers all types of documents received 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.	AM 09.01, DC.1.1.3.1
Draft1.614	LT 09.02	External clinical documents	The system shall provide the ability to save scanned documents as images.	2011	N				AM 09.03, DC.1.1.3.1
Draft1.615	LT 09.03	External clinical documents	The system shall provide the ability to receive, store in the patient's record, and display text-based outside reports.			R		This could be either from an outside system or from scanning with optical character recognition.	AM 09.04, DC.1.1.3.1
Draft1.616	LT 09.04	External clinical documents	The system shall provide the ability to index scanned documents and associate a date and document type to the document.	2011	N			These dates may include the date the original document was produced, received, and/or scanned.  Indexing implies associating a scanned document with an individual patient record.	AM 09.05.01
Draft1.617	LT 09.05	External clinical documents	The system shall provide the ability to retrieve indexed scanned documents based on document type and date.	2011	N			Document types might include lab notes, progress notes, etc.	AM 09.05.02
Draft1.618	LT 09.06	External clinical documents	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.			R		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.	AM 09.06, DC.1.1.3.1
Draft1.619	LT 09.07	External clinical documents	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.			R		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.	AM 09.07, DC.1.1.3.1
Draft1.620	LT 10.01	Patient-specific instructions	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.			R		An example would be a vaccine information statement.	FN 14.01

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Draft1.621	LT 10.02	Patient-specific instructions	The system shall have the ability to provide access to patient-specific test and procedure instructions that can be modified 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.	2011	NH			It is not required that the modified document be stored in the patient record. This will be required for Skilled Nursing in the future.	AM 10.03
Draft1.622	LT 10.03	Patient-specific instructions	The system shall provide the ability to record that patient specific instructions or educational material were provided to the patient.			R		This does not require automatic documentation.	AM 10.05, DC.1.10
Draft1.623	LT 10.04	Patient-specific instructions	The system shall provide the ability to create patient specific instructions.			R			AM 10.06, DC.1.10
Draft1.624	LT 10.05	Patient-specific instructions	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.	2011	N				FN 17.01
Draft1.625	LT 11.01	General Ordering Requirements	The system shall provide the ability to document a verbal order (including telephone orders); documentation shall include the ordering clinician as well as the clinician taking the verbal order.	2011	N				IP 08.05, DC.3.2.1
Draft1.626	LT 11.02	General Ordering Requirements	The system shall provide the ability to document a verification "read-back" of the complete order by the person receiving the telephone or verbal order.	2011	N			Free text is sufficient for now, discrete data in the future.	IP 08.07, JCAHO 2003 National Patient Safety Goal - Goal 2: Improve the effectiveness of communication among caregivers
Draft1.627	LT 11.03	General Ordering Requirements	The system shall provide the ability to prohibit verbal orders by role.			R		For example, a Medical Student role cannot be selected for verbal order provider.	IP 08.08
Draft1.628	LT 11.04	General Ordering Requirements	The system shall provide the ability to include urgency status in orders.			R		For example, routine, Now, or STAT, and should be in a discrete field.	IP 08.09
Draft1.629	LT 11.05	General Ordering Requirements	The system shall provide the ability for clinicians to enter all patient care orders electronically, including, but not limited to nursing care, medications/immunizations, diagnostic testing, nutrition and food service, consultation, and blood products.	2011	N				IP 08.10, DC 1.7.2.1, DC 1.7.2.2
Draft1.630	LT 11.06	General Ordering Requirements	The system shall provide the ability to renew, modify, and discontinue orders.	2011	N				IP 08.11, DC.1.7.1
Draft1.631	LT 11.07	General Ordering Requirements	The system shall provide the ability to notify the receiving department with any order action of new, renew, modify or discontinue.			R		For example, a medication dose or frequency is changed (pharmacy notified) or a lab frequency is changed (lab notified).	IP 08.12, Implied in DC.1.7.2; DC.1.7.2.1 (6); DC.1.7.2.2 (6);
Draft1.632	LT 11.08	General Ordering Requirements	For each order type, the system shall provide the ability to capture and display the identity of the user, the date and the time when the order is signed, co-signed, renewed, modified or discontinued.			R			IP 08.13, DC.1.7.1 (and others)
Draft1.633	LT 11.09	General Ordering Requirements	The system shall provide the ability to display order history for any order, including the ordering clinician, order details, date, and time.	2011	N				IP 08.14
Draft1.634	LT 11.10	General Ordering Requirements	The system shall provide the ability to display orders for a patient by different views.	2011	N			For example, active, discontinued, all, date, ordering clinician, and type.	IP 08.27
Draft1.635	LT 11.11	General Ordering Requirements	The system shall provide the ability to designate access to entering individual types of orders by user role.	2011	N				IP 08.32
Draft1.636	LT 11.12	General Ordering Requirements	The system shall provide the ability to require a problem/diagnosis as an order component.			RS			FN 09.01
Draft1.637	LT 11.13	General Ordering Requirements	The system shall provide the ability to view status information for ordered services.	2011	N			Status may be electronically or manually updated.	FN 09.02
Draft1.638	LT 11.14	General Ordering Requirements	The system shall provide the ability to set or configure what fields are required for a complete order by individual order or type of order.			R			FN 09.03
Draft1.639	LT 12.01	Medication Prescribing and Ordering	The system shall provide the ability to create prescription or other medication orders with sufficient information for correct filling and dispensing by a pharmacy including entering dosing instructions in free text.	2011	NS			Example of dosing instructions is "pea-sized amount" for topical medications. This will be required for LTPAC domain in the future.	AM 11.01.01
Draft1.640	LT 12.02	Medication Prescribing and Ordering	The system shall provide the ability to record user and date stamp for prescription related events, such as initial creation, renewal, discontinuation, and cancellation of a prescription.	2011	NS				AMB 11.02, DC.1.7.1
Draft1.641	LT 12.03	Medication Prescribing and Ordering	The system shall provide the ability to capture the identity of the prescribing provider for all medication orders.	2011	N				AM 11.03, DC.1.7.1

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Draft1.642	LT 12.04	Medication Prescribing and Ordering	The system shall provide the ability to capture common content for medication order details including strength, sig, and quantity to be selected by the ordering clinician.	2011	N			The WG encourages the development of standard national abbreviations and that only approved abbreviations should be supported.	AMB 11.08, DC.1.7.1
Draft1.643	LT 12.05	Medication Prescribing and Ordering	The system shall provide the ability to specify medication order details including dose, route, frequency and comments. Dose, route and frequency must be captured and maintained as discrete data.	2011	N				FN 07.06
Draft1.644	LT 12.06	Medication Prescribing and Ordering	The system shall provide the ability to reorder a prior prescription without re-entering previous data (e.g. administration schedule, quantity).	2011	NS				AM 11.07, DC.1.7.1
Draft1.645	LT 12.07	Medication Prescribing and Ordering	The system shall provide the ability to print and electronically fax prescriptions.			RS			AM 11.08, DC.1.7.1
Draft1.646	LT 12.08	Medication Prescribing and Ordering	The system shall provide the ability to re-print and re-fax prescriptions.			RS		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.	AM 11.09
Draft1.647	LT 12.09	Medication Prescribing and Ordering	The system shall provide the ability to display a dose calculator for patient-specific dosing based on weight.				R	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 (e.g. "250"). It is not required that the dose calculator automatically populate fields in the prescription itself.	AM 11.11, DC.1.7.1
Draft1.648	LT 12.10	Medication Prescribing and Ordering	The system shall provide the ability to prescribe fractional amounts of medication (e.g. 1/2 tsp, 1/2 tablet).	2011	N				AM 11.13, DC.1.7.1
Draft1.649	LT 12.11	Medication Prescribing and Ordering	The system shall provide the ability to express dosing instructions in free text.	2011	N			For example, 'pea-sized amount' for topical medications. The WG encourages standardization of common terms.	AM 11.13.01
Draft1.650	LT 12.12	Medication Prescribing and Ordering	The system shall provide the ability to allow the user to configure prescriptions to incorporate fixed text according to the user's specifications.			RS		This refers to the "written" output and language on the printed prescription such as practice address, practice telephone number, legally mandated text. For instance, users should be able to modify the format/content of printed prescriptions to comply with state Board of Pharmacy requirements.	AM 11.15
Draft1.651	LT 12.13	Medication Prescribing and Ordering	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 prescriptions and medications ordered for administration).	2011	N				FN 09.04
Draft1.652	LT 12.14	Medication Prescribing and Ordering	The system shall provide the ability to display the associated problem or diagnosis (indication) on the printed prescription.			RS		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.	AM 11.17
Draft1.653	LT 12.15	Medication Prescribing and Ordering	The system shall provide the ability to add reminders for necessary follow up tests based on medication prescribed.	2011	NS			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.	AM 11.20
Draft1.654	LT 12.16	Medication Prescribing and Ordering	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.	2011	N			The intent is to have the ability for one user to enter an order, place it in "pending" or similar status, so that a subsequent provider can complete and submit the order.	AM 11.22

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Draft1.655	LT 12.17	Medication Prescribing and Ordering	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.	2011	N				FN 07.01
Draft1.656	LT 12.18	Medication Prescribing and Ordering	The system shall provide the ability to prescribe/order/record uncoded and non-formulary medications.	2011	N				FN 07.02
Draft1.657	LT 12.19	Medication Prescribing and Ordering	The system shall provide the ability to maintain a coded list of medications including a unique identifier for each medication.	2011	N				FN 07.03
Draft1.658	LT 12.20	Medication Prescribing and Ordering	The system shall provide end-users the ability to search for medications by generic or brand name.	2011	N				FN 07.04
Draft1.659	LT 12.21	Medication Prescribing and Ordering	The system shall provide the ability to access reference information for prescribing/ordering/recording of medications.	2011	N			The reference information may reside within the system or be provided through links to external sources.	FN 07.05
Draft1.660	LT 12.22	Medication Prescribing and Ordering	The system shall provide the ability to search from medication lists which use "Tall Man" letters.			R		For example, DOBUTamine and DOPamine.	IP 12.12
Draft1.661	LT 12.23	Medication Prescribing and Ordering	The system shall provide the ability to check for potential interactions between medications to be prescribed/ordered/recorded and current medications and alert the user at the time of medication prescribing/ordering/recording if potential interactions exist.	2011	N				FN 12.01, DC.2.3.1.1
Draft1.662	LT 13.01	Drug interaction	The system shall provide the ability to alert the user if the drug interaction information is outdated.			R		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.	AM 11.14
Draft1.663	LT 13.02	Drug interaction	The system shall provide the ability to set the severity level at which drug interaction warnings should be displayed.			R			AM 19.05, DC.2.3.1.1
Draft1.664	LT 13.03	Drug interaction	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.			R		'Ordered for administration' refers to administration at the site of care.  This criterion is dependent on drug knowledge database being made available by the drug database vendor.	AM 19.06
Draft1.665	LT 13.04	Drug interaction	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.			R		This criterion assumes that at the time a medication was discontinued, it was marked "ineffective."	AM 19.07, DC.2.3.1.1
Draft1.666	LT 13.05	Drug interaction	The system shall provide the ability to display, on demand, potential drug-allergy interactions, drug-drug interactions, and drug-diagnosis interactions based on current medications, active allergies, and active problems.			R			FN 12.04
Draft1.667	LT 13.06	Drug interaction	The system shall provide drug-diagnosis interaction alerts at the time of medication prescribing/ordering/recording.			R			FN 13.01
Draft1.668	LT 13.07	Drug interaction	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.			R		'Ordered for administration' refers to administration at the site of care.  This criterion is dependent on drug knowledge database being made available by the drug database vendor.	AM 19.10
Draft1.669	LT 13.08	Drug interaction	The system shall provide drug-disease interaction alerts based on the patient's medications at the time of entering a problem.			R			AM 19.11
Draft1.670	LT 13.09	Drug interaction	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.	2011	N				FN 12.11
Draft1.671	LT 13.10	Drug interaction	The system shall provide the ability to check for medication contraindications based on patient age and alert the user during prescribing/ordering/recording.			R		For example, Tetracycline is listed as a high risk for older adult patients using the Beers criteria.	FN 08.06

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Draft1.672	LT 13.11	Drug interaction	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.			R			FN 12.02
Draft1.673	LT 13.12	Drug interaction	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.			R		Until third-party vendors support this functionality in databases, this may require manual configuration by organization.	FN 12.03
Draft1.674	LT 13.13	Drug interaction	The system shall provide the ability to view the rationale for a drug interaction alert.	2011	N				FN 12.05
Draft1.675	LT 13.14	Drug interaction	The system shall provide the ability to capture and maintain at least one reason for overriding any drug-drug or drug-allergy/intolerance interaction warning triggered at the time of medication prescribing/ordering/recording.			R			FN 12.06
Draft1.676	LT 13.15	Drug interaction	The system shall provide the ability to enter a structured response when overriding a drug-drug or drug-allergy/intolerance warning.			R			FN 12.07
Draft1.677	LT 13.16	Drug interaction	The system shall provide the ability to prescribe/order a medication despite alerts for interactions and/or allergies/intolerances being present.	2011	N				FN 12.08, DC.2.3.1.1
Draft1.678	LT 13.17	Drug interaction	The system shall provide the ability to accept updates to drug interaction databases.	2011	N				FN 12.09
Draft1.679	LT 13.18	Drug interaction	The system shall provide the ability to display patient specific dosing recommendations based on renal function.			R			FN 08.02
Draft1.680	LT 14.01	Medication Reconciliation	The system shall provide the ability to capture and display home medications for medication reconciliation during entering of admission orders.	2011	N				IP 11.07
Draft1.681	LT 14.02	Medication Reconciliation	At admission and discharge from the facility, the system shall provide the ability to permit the clinician to designate which home medications are being continued/discontinued.			R			IP 11.08
Draft1.682	LT 14.03	Medication Reconciliation	At admission, discharge, and each change in level of care during the facility stay, the system shall provide the ability to capture a signature indicating that medication reconciliation has been completed.	2011	N				IP 11.13
Draft1.683	LT 14.04	Medication Reconciliation	At admission, discharge, and each change in level of care, the system shall provide the ability to retain the history of medication reconciliation (including prior medications reviewed, medications continued/discontinued, new medication orders, signature of each provider completing review) for subsequent review.			R			IP 11.14
Draft1.684	LT 15.01	Order diagnostic tests	The system shall provide the ability to order diagnostic tests, including labs and imaging studies.	2011	N			This includes physicians and authorized non-physicians.	AM 12.01, DC.1.7.2.2
Draft1.685	LT 15.02	Order diagnostic tests	The system shall provide the ability to capture the identity of the ordering/authorizing provider for all test orders.	2011	N				AM 12.02
Draft1.686	LT 15.03	Order diagnostic tests	The system shall provide the ability to capture appropriate order entry detail, including associated diagnosis.	2011	N				AM 12.03, DC.1.7.2.2
Draft1.687	LT 15.04	Order diagnostic tests	The system shall provide the ability to display instructions and/or prompts when ordering diagnostic tests or procedures.			RS		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.	AM 12.04, DC.1.7.2.2
Draft1.688	LT 15.05	Order diagnostic tests	The system shall provide the ability to relay orders for a diagnostic test to the correct destination for completion.	2011	N			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.	AM 12.05, DC.1.7.2.2
Draft1.689	LT 15.06	Order diagnostic tests	The system shall provide the ability to provide a view of active orders for an individual patient.	2011	N			Additional sorts and filters may be provided by a system but not required.	AM 12.06, DC.1.7.2.2
Draft1.690	LT 15.07	Order diagnostic tests	The system shall provide the ability to provide a view of orders by like or comparable type, e.g., all radiology or all lab orders.	2011	N			May include filters or sorts.	AM 12.07, DC.1.7.2.2
Draft1.691	LT 15.08	Order diagnostic tests	The system shall provide the ability to display outstanding orders for multiple patients (as opposed to outstanding orders for a single patient).	2011	N			A report may satisfy this criterion. Multiple patients may be defined as all patients in the organization or a subset.	AM 12.08

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Draft1.692	LT 15.09	Order diagnostic tests	The system shall provide the ability for a user to select an order for a diagnostic test 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.			RS		The intent is to have the ability for one user to enter an order, place it in "pending" or similar status, so that a subsequent provider can complete and submit the order.	AM 12.09
Draft1.693	LT 16.04	Referral Management	The system shall provide the ability to capture and communicate referral(s) to other care provider(s), whether internal or external to the organization.			R			DC.1.7.2.4
Draft1.694	LT 16.05	Referral Management	The system shall provide the ability to capture clinical details as necessary for the referral.			R			DC.1.7.2.4
Draft1.695	LT 16.06	Referral Management	The system shall provide the ability to capture and display administrative details (such as insurance information, consents, and authorizations for disclosure) as necessary for the referral.			R			DC.1.7.2.4
Draft1.696	LT 16.07	Referral Management	The system shall provide the ability to capture completion of a referral appointment.			R		Currently this could be met through a scanned report or a free text note. This is not the creation of the appointment itself. It is the documentation that the referral appointment has occurred.	DC.1.7.2.4
Draft1.697	LT 16.08	Referral Management	The system shall have the ability to present recommendations for potential referrals based on patient condition (e.g. conditions triggered from MDS such as declining ADL's, vision or hearing problems, abnormal lab values, recommendation for medication evaluation, etc).			R			DC.2.4.4.2
Draft1.698	LT 16.09	Referral Management	The system shall provide the ability to record user ID and date/time stamp for all referral related events.	2011	N			Necessary for medico-legal purposes.	AM 21.02, DC.2.4.2
Draft1.699	LT 17.01	Order Sets	The system shall provide the ability to define a set of items to be ordered as a group.			R		The intent is that the Order Set thus defined will be used across multiple patients on multiple occasions.	FN 10.01
Draft1.700	LT 17.02	Order Sets	The system shall provide the ability to modify order sets.			R			FN 10.02
Draft1.701	LT 17.03	Order Sets	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.			R			FN 10.03
Draft1.702	LT 17.04	Order Sets	The system shall provide the ability for individual orders in an order set to be selected or deselected by the user.			R			FN 11.01
Draft1.703	LT 17.05	Order Sets	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.			R			FN 11.03
Draft1.704	LT 17.06	Order Sets	The system shall provide the ability to display orders placed through an order set either individually or as a group.			R			FN 11.04
Draft1.705	LT 18.01	Specimen Collection	The system shall provide the ability to present information necessary to correctly identify the patient and accurately identify the specimen to be collected including, but not limited to, patient name, specimen type, specimen source, means of collection, date, and time.			RS			DC.2.4.5.2
Draft1.706	LT 18.02	Specimen Collection	The system shall provide the ability to report variation between the type of specimen order placed and actual specimen received.			RS			DC.2.4.5.2
Draft1.707	LT 18.03	Specimen Collection	The system shall provide the ability to capture the details of specimen collection.			RS			DC.2.4.5.2
Draft1.708	LT 19.01	Results	The system shall provide the ability to indicate normal and abnormal results based on data provided from the original data source.	2011	N			As each lab defines normal values, these should be reflected in the indication as to whether a lab is normal or abnormal.	AM 14.01, DC.1.8.3
Draft1.709	LT 19.02	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.			R		It is desirable for the system indicate if abnormal results are high or low.	AM 14.02, DC.1.8.3
Draft1.710	LT 19.03	Results	The system shall provide the ability to display non-numeric current and historical test results as textual data.	2011	N				AM 14.03, DC.1.8.3

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Draft1.711	LT 19.04	Results	The system shall provide the ability to notify the relevant providers (ordering, copy to) that new results have been received.	2011	N			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. May include an alert.	AM 14.04, DC.1.8.3
Draft1.712	LT 19.05	Results	The system shall provide the ability to filter or sort results by type of test and test date.			R			AM 14.05
Draft1.713	LT 19.06	Results	The system shall provide the ability to forward results or forward an alert that new results are available to other users.	2011	N				AM 14.07, DC.1.8.3
Draft1.714	LT 19.07	Results	The system shall provide the ability to link the results to the original order.			R		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. Not all types of orders can be electronically linked given the variety of result formats (e.g., PT consults, diabetes education).	AM 14.08, DC.1.8.3
Draft1.715	LT 19.08	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.	2011	N				AM 14.09, DC.1.8.3
Draft1.716	LT 19.09	Results	The system shall provide the ability to associate one or more images with a non-numerical result.			R		Through direct storage or links to the data.	AM 14.10, DC.1.8.3
Draft1.717	LT 19.10	Results	The system shall provide the ability for a user to whom a result is presented to acknowledge the result.			R		This is separate from audit trail.	AM 14.11, DC.1.8.3
Draft1.718	LT 20.01	Consents and authorizations	The system shall provide the ability to capture scanned paper consent documents.	2011	N				AM 15.01, DC.1.3.3
Draft1.719	LT 20.02	Consents and authorizations	The system shall provide the ability to store, display, and print patient consent forms.	2011	N			For 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 when widely available.	AM 15.02, DC.1.3.3
Draft1.720	LT 20.03	Consents and authorizations	The system shall provide the ability to display and maintain electronic consent forms for patients using currently available digital signature standards. Electronically signed consent forms shall be maintained within the patient medical record.			R		This depends on the establishment of national infrastructure for managing digital signatures at the point of care.	AM 15.03
Draft1.721	LT 20.04	Consents and authorizations	The system shall provide the ability to store and display administrative documents (e.g. privacy notices).	2011	N			Needed for HIPAA. Scanned copy is acceptable for current year.	AM 15.04, DC.1.3.3
Draft1.722	LT 20.05	Consents and authorizations	The system shall provide the ability to chronologically display consents and authorizations.	2011	N				AM 15.05, DC.1.3.3
Draft1.723	LT 20.06	Consents and authorizations	The system shall provide the ability to sort and consents and authorizations chronologically, reverse chronologically, and by type.	2011	N				DC.1.3.3
Draft1.724	LT 20.07	Consents and authorizations	The system shall provide the ability to document the source of each consent and authorization, such as the patient or the patient's personal representative if the patient is legally unable to provide it.			R			DC.1.3.3
Draft1.725	LT 20.08	Consents and authorizations	The system shall provide the ability to document the patient's personal representative's level of authority to make decisions on behalf of the patient.			R		This may captured using free text	DC.1.3.3
Draft1.726	LT 21.01	Patient advance directives	The system shall provide the ability to indicate that a patient has completed advance directive(s).	2011	N			Important for appropriate use of resources at end of life and may just include a yes, no indication.	AM 16.01, DC.1.3.2
Draft1.727	LT 21.02	Patient advance directives	The system shall provide the ability to indicate the type of advance directives, such as a living will, durable power of attorney, or a "Do Not Resuscitate" order.	2011	N			This may be recorded in non-structured data or as discrete data.	AM 16.02, DC.1.3.2
Draft1.728	LT 21.03	Patient advance directives	The system shall provide the ability to indicate when advance directives were last reviewed.			R		This may be recorded in non-structured data or as discrete data.	AM 16.03, DC.1.3.2
Draft1.729	LT 21.04	Patient advance directives	The system shall provide the ability to record and display the expiration data of the advance directives.			R			Source is WG discussion.
Draft1.730	LT 21.05	Patient advance directives	The system shall provide the ability to indicate the name and relationship of the party completing the advance directive for the patient.	2011	N				DC.1.3.2
Draft1.731	LT 21.06	Patient advance directives	The system shall provide the ability to time and date stamp the entry of advance directives information.	2011	N				DC.1.3.2

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Draft1.732	LT 22.01	Care plans, guidelines, protocols	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.	2011	N			This requirement could be met by 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.	AM 17.01, DC.2.2.1.1
Draft1.733	LT 22.02	Care plans, guidelines, protocols	The system shall provide the ability to create patient-specific care plan.	2011	N			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. This includes the ability to customize care plans at the patient level.	DC.2.2.1.1
Draft1.734	LT 22.03	Care plans, guidelines, protocols	The system shall provide the ability to modify patient-specific standard care plan, protocol, and guideline documents obtained from outside sources.	2011	N			For example, transitions of care. This need not be an automated process.	AM 17.03, DC.2.2.1.1
Draft1.735	LT 22.04	Care plans, guidelines, protocols	The system shall provide the ability to maintain and display multiple component careplans/carepaths per patient.	2011	NH			This could be accomplished with multiple care plans or a single careplan that allows for the management of multiple problems.	Source is WG discussion.
Draft1.736	LT 22.05	Care plans, guidelines, protocols	The system shall provide the ability to maintain and display discipline specific careplans/carepaths.	2011	NH			This could include a filter that permits each discipline to see their portion of the careplan.	Source is WG discussion.
Draft1.737	LT 22.06	Care plans, guidelines, protocols	The system shall provide the ability to specify that a careplan applies to multiple disciplines.	2011	NH				Source is WG discussion.
Draft1.738	LT 22.07	Care plans, guidelines, protocols	The system shall provide the ability for goals to be viewed by all disciplines.	2011	N				Source is WG discussion.
Draft1.739	LT 22.08	Care plans, guidelines, protocols	The system shall provide the ability for assessment answers to trigger suggested care plans/pathways/interventions.	2011	NS			This will be required in the LTPAC base certification in the future.	Source is WG discussion.
Draft1.740	LT 22.09	Care plans, guidelines, protocols	The system shall provide the ability to specify the plan for the next visit.				RH		Source is WG discussion.
Draft1.741	LT 22.10	Care plans, guidelines, protocols	The system shall provide the ability to view the plans for the next visit plans on the subsequent visit.				RH		Source is WG discussion.
Draft1.742	LT 23.01	Medication Administration	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.				R		FN 15.01
Draft1.743	LT 23.02	Medication Administration	The system shall provide the ability to present the list of medications that are to be administered.	2011	N				DC.1.8.1
Draft1.744	LT 23.03	Medication Administration	The system shall provide the ability to display the timing (e.g. frequency and hour of administration), route of administration, and dose of all medications on the list.	2011	N			This can be accomplished using free text.	DC.1.8.1
Draft1.745	LT 23.04	Medication Administration	The system shall provide the ability to display order directions (SIG) for administration of all medications on the list.	2011	N			This can be accomplished using free text.	DC.1.8.1
Draft1.746	LT 23.05	Medication Administration	The system shall provide the ability to indicate when medication related activities are due.	2011	NS				DC.1.8.1
Draft1.747	LT 23.06	Medication Administration	The system shall provide the ability to capture medication administration details, including timestamps, observations, complications, and the reason why a medication was not administered.				R		DC.1.8.1
Draft1.748	LT 23.07	Medication Administration	The system shall provide the ability to present information necessary to correctly identify the patient and accurately administer medications and immunizations such as medication name, strength, dose, route and frequency, and patient name, patient photo, or other means of positive patient identification.	2011	NS				DC.2.3.2
Draft1.749	LT 23.08	Medication Administration	The system shall provide the ability to alert providers to potential administration errors (such as wrong patient, wrong drug, wrong dose, wrong route, and wrong time) as it relates to medication and immunization administration.				RS		DC.2.3.2

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Draft1.750	LT 23.09	Medication Administration	The system shall provide the ability to alert providers to potential medication administration errors at the point of medication administration.			RS			DC.2.3.2
Draft1.751	LT 24.01	Immunization Management	The system shall provide the ability to capture, in a discrete field, an allergy/adverse reaction to a specific immunization.			R			FN 16.02
Draft1.752	LT 24.02	Immunization Management	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.			R			FN 16.03
Draft1.753	LT 24.03	Immunization Management	The system shall provide the ability to enter new vaccine dosing schedules into the system.	2011	N				IP 12.41
Draft1.754	LT 24.04	Immunization Management	The system shall provide the ability to inform the clinician when immunizations are recommended.			R			IP 12.42
Draft1.755	LT 24.05	Immunization Management	The system shall provide the ability to document clinical assessment pertinent to immunization administration.	2011	N			An example is common screening questions/actions asked prior to administering a vaccine, i.e., taking the patient's temperature, asking if there is an allergy to eggs. Free text is acceptable for now, should be discrete data in the future.	IP 15.07
Draft1.756	LT 24.06	Immunization Management	The system shall provide the ability to print the immunization administration record.	2011	N				IP 15.11
Draft1.757	LT 24.07	Immunization Management	The system shall provide the ability to record the consent, refusal, or deferral status as it relates to the administration of each immunization at the time of each encounter, including: the date and time; the decision (consent, refusal, or deferral); and name of authorizing individual and status of authorizing individual (e.g. parent, self, legal guardian, medical power of attorney).	2011	N			Free text is acceptable for now, should be discrete data in the future	IP 15.12, PeDSSIG, AAP
Draft1.758	LT 25.01	Blood Administration	The system shall provide the ability to present information necessary to correctly identify the patient and accurately administer blood products, including patient name, blood product number, amount, route, product expiration date and time of administration.			RS			DC.2.4.5.1
Draft1.759	LT 25.02	Blood Administration	The system shall provide the ability to capture validation that the correct match of the patient to the blood product occurred.			RS			DC.2.4.5.1
Draft1.760	LT 25.03	Blood Administration	The system shall provide the ability to capture the blood product number, amount, route, and time of administration.			RS			DC.2.4.5.1
Draft1.761	LT 25.04	Blood Administration	The system shall provide the ability to capture the blood pressure, temperature, pulse, and respirations of the patient receiving the product.			RS			DC.2.4.5.1
Draft1.762	LT 26.01	Disease management, preventive services and wellness	The system shall provide the ability for the provider to override established treatment guidelines.			R		The end user can override guidelines when appropriate to a specific clinical situation.	DC.2.5.1
Draft1.763	LT 26.02	Disease management, preventive services and wellness	The system shall provide the ability for the user to document the reason(s) for overriding established treatment guideline alerts.			R		Needed for medico-legal reasons and clinical decision support.	DC.2.5.1
Draft1.764	LT 26.03	Disease management, preventive services and wellness	The system shall provide the ability to modify the rules or parameters upon which treatment guideline alerts are based.			R		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
Draft1.765	LT 26.04	Disease management, preventive services and wellness	The system shall provide the ability to document that adherence to an established treatment guideline was performed based on activities documented in the record (e.g. vitals signs taken).			R			AM 22.09, DC.2.5.1

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Draft1.766	LT 26.05	Disease management, preventive services and wellness	The system shall provide the ability to individualize alerts to address a patient's specific clinical situation.			R		This is done at the patient level. Examples include but are not limited to: removing a mammography reminder for woman that has had a mastectomy; removing an annual pap smear alert for a woman who has had a complete hysterectomy; or inactivate an alert for routine colon cancer screening in a patient who is terminally ill.	AM 22.11
Draft1.767	LT 26.06	Disease management, preventive services and wellness	The system shall provide the ability to identify preventive services, tests, or counseling that are due for an individual patient.			R			AM 23.01, DC.2.5.2
Draft1.768	LT 26.07	Disease management, preventive services and wellness	The system shall provide the ability to display reminders for disease management, preventive, and wellness services in the patient record.			R			AM 23.02, DC.2.5.2
Draft1.769	LT 26.08	Disease management, preventive services and wellness	The system shall provide the ability to notify the provider that patients are due or are overdue for disease management, preventive, and wellness services.			R			AM 23.06, DC.2.5.2
Draft1.770	LT 26.09	Disease management, preventive services and wellness	The system shall provide the ability to produce a list of patients who are due or are overdue for disease management, preventive and wellness services.			R		For example, getting their flu, pneumonia, or shingles vaccine.	AM 23.07, DC.2.5.2
Draft1.771	LT 26.10	Disease management, preventive services and wellness	The system shall provide the ability to automatically generate an electronic/online reminder to the patient or the patient's guardian of disease management, preventive, or wellness services coming due or those that are overdue.			R		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. The WG will work with interoperability to determine the appropriate certification year, based on availability of secure messaging criteria. Messages could be sent by the EHR or through a third-party. Electronic/online reminders could include secure email, PHR, or text message.	AM 23.10
Draft1.772	LT 27.01	Clinical Task Management	The system shall provide the ability to create and assign tasks by user or user role.	2011	N			Examples of tasks are messages, notifications, inbox items, worklist to-dos. This task assignment refers to internal users. External tasks would be handled under Ordering category.	AM 24.01, DC.3.1.1
Draft1.773	LT 27.02	Clinical Task Management	The system shall provide the ability to present a list of tasks by user or user role.	2011	N			Examples of tasks are messages, notifications, inbox items, worklist to-dos. This task assignment refers to internal users. External tasks would be handled under ordering section.	AM 24.02, DC.3.1.1
Draft1.774	LT 27.03	Clinical Task Management	The system shall provide the ability to re-assign and route tasks from one user to another user.	2011	N				AM 24.03, DC.3.1.1
Draft1.775	LT 27.04	Clinical Task Management	The system shall provide the ability to designate a task as completed.	2011	N				AM 24.04, DC.3.1.1
Draft1.776	LT 27.05	Clinical Task Management	The system shall provide the ability to remove a task without completing the task.	2011	N			Removing a task eliminates it from an individual user's 'to do' list, not from audit logs, etc.	AM 24.05, DC.3.1.1
Draft1.777	LT 27.06	Clinical Task Management	The system shall provide the ability to notify the clinician of overdue medication administrations.	2011	NS				IP 17.03
Draft1.778	LT 27.07	Clinical Task Management	The system shall provide the ability to notify the ordering clinician concerning orders due to expire.	2011	NS				IP 17.05
Draft1.779	LT 27.08	Clinical Task Management	The system shall provide the ability to notify the ordering clinician concerning orders requiring signature (verbal and telephone orders, co-signature).			RS		For example, verbal and telephone orders, co-signature.	IP 17.08
Draft1.780	LT 27.09	Clinical Task Management	The system shall provide the ability to the provider to redirect the notification concerning orders requiring signature to another provider.			RS		The provider may know the responsible provider (mistake or change since order placed). An audit trail should be created which records both the original and new responsible clinician.	IP 17.09

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Draft1.781	LT 28.01	Inter-provider communication	The system shall provide the ability to document verbal/telephone communication into the patient record.	2011	N			Free text is acceptable.	AM 25.01, DC.3.2.1
Draft1.782	LT 28.02	Inter-provider communication	The system shall provide the ability to support messaging between users.	2011	N			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.	AM 25.03, DC.3.2.1
Draft1.783	LT 28.03	Inter-provider communication	The system shall provide the ability to capture and display documentation by clinicians of their communication with the patient's physician.	2011	N				Source is WG discussion.
Draft1.784	LT 29.01	Provider Information	The system shall provide the ability to assign clinicians to appropriate teams, where teams are defined as groups of clinicians who share responsibility for covering the same group of patients.			R			IP 02.02, S.1.3.5
Draft1.785	LT 29.02	Provider Information	The system shall provide the ability to maintain a directory which identifies the physician by multiple unique identifiers.	2011	N				IP 02.05, 45 CFR Part 162
Draft1.786	LT 29.03	Provider Information	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.	2011	N			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.	FN 03.01, S.3.4
Draft1.787	LT 29.04	Provider Information	The system shall provide the ability to capture and maintain, as discrete data elements, the specific role of all providers associated with a specific patient.	2011	N			For example, responsible physician, attending, admitting, primary care provider, consulting, nurse, therapist, or pharmacist.	FN 03.01.01
Draft1.788	LT 29.05	Provider Information	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.	2011	N				FN 03.02, S.3.4
Draft1.789	LT 29.06	Provider Information	The system shall provide the ability to maintain a directory of all clinical personnel who currently use or access the system.	2011	N				AM 27.01, S.1.3.1
Draft1.790	LT 29.07	Provider Information	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.	2011	N			This directory may be the same as that in criterion LT 29.06 for this functionality.	AM 27.02, S.1.3.1
Draft1.791	LT 29.08	Provider Information	The system shall provide the ability for authorized users to update the directory.	2011	N			Authorized user is not necessarily the same as the Directory Administrator.	AM 27.03, S.1.3.1
Draft1.792	LT 29.09	Provider Information	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.	2011	N			Referral sources, attending physicians, DME providers, pharmacies, regulatory agencies, Adult Protection and families.	AM 27.04, S.1.3.1
Draft1.793	LT 30.01	Medical Equipment	The system shall provide the ability to capture a list of the patient's specialized medical equipment and each prosthetic, orthotic, or implantable device as unique, discrete entries.	2011	N				DC.1.4.5
Draft1.794	LT 30.02	Medical Equipment	The system shall provide the ability to capture the reason for the specialized medical equipment and each prosthetic, orthotic, or implantable device.			R			DC.1.4.5
Draft1.795	LT 30.03	Medical Equipment	The system shall provide the ability to capture the specific type of specialized medical equipment, prosthetic, orthotic, or implantable device.			R			DC.1.4.5
Draft1.796	LT 30.04	Medical Equipment	The system shall provide the ability to capture in a discrete field that the patient has No Known specialized medical equipment or prosthetic, orthotic, or implantable device for the patient.	2011	N				DC.1.4.5
Draft1.797	LT 30.05	Medical Equipment	The system shall provide the ability to capture information necessary to identify and track the equipment/device as discrete entries. Such information may include, but is not limited to: type, manufacturer, manufacture date, date implanted (or placed into service), model/serial number, anatomical location, etc.			R			DC.1.4.5
Draft1.798	LT 30.06	Medical Equipment	The system shall provide the ability to delete or inactivate the documentation of the specialized medical equipment or prosthetic, orthotic, or implantable devices.	2011	N				DC.1.4.5

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Draft1.799	LT 30.07	Medical Equipment	The system shall provide the ability to present a list of the deleted inactivated/discontinued specialized medical equipment or prosthetic, orthotic, or implantable devices and reason for deletion.	2011	N				DC.1.4.5
Draft1.800	LT 30.08	Medical Equipment	The system shall provide the ability to electronically receive and maintain relevant clinical data captured by telehealth devices in the patient's home.				RH	If patient is participating in telehealth.	Source is WG discussion.
Draft1.801	LT 31.01	Assessment Instrument	The system shall provide the ability to capture all data elements as defined in the most recent federally mandated assessment applicable to the care site.	2011	N			For example, MDS in nursing homes and OASIS in home health.	DC.1.5.1
Draft1.802	LT 31.02	Assessment Instrument	The system shall provide the ability to perform Medicare payment calculations from federally mandated assessment data items in accordance with the most recent algorithms provided by CMS and populate the payment calculation value to the appropriate federally mandated assessment data element.	2011	N			Example: RUG (Resource Utilization Groups) in Home Health.	DC.1.5.1
Draft1.803	LT 31.03	Assessment Instrument	The system shall provide the ability to perform State Medicaid payment calculations from federally mandated assessment data items in accordance with the most recent algorithms provided by the state agency of the jurisdiction in which the system is implemented, and populate the payment calculation value to the appropriate data element as required by jurisdictional law or regulation.	2011	N			Applicants might be required to self-attest to compliance in the states where the vendor markets products.	DC.1.5.1
Draft1.804	LT 31.04	Assessment Instrument	The system shall provide the ability to perform data consistency edits as defined in the most recent federally mandated assessment data specification.	2011	N				DC.1.5.1
Draft1.805	LT 31.05	Assessment Instrument	The system shall provide the ability to calculate Care Area Triggers (CAT) in accordance with the most recent federally mandated assessment data specification.	2011	NS				DC.1.5.1
Draft1.806	LT 31.06	Assessment Instrument	The system shall provide the ability to capture the clinician assessment process for triggered Care Area Triggers.	2011	NS				DC.1.5.1
Draft1.807	LT 31.07	Assessment Instrument	The system shall provide the ability to create federally mandated assessment data submission files in accordance with the most recent data specifications.	2011	N			For example, MDS in nursing homes and OASIS in home health.	DC.1.5.1
Draft1.808	LT 31.08	Assessment Instrument	The system shall provide the ability to implement federally mandated assessment data correction and assessment locking processes as defined in the most recent version of the CMS Correction Policy.	2011	N			For example, MDS in nursing homes and OASIS in home health.	DC.1.5.1
Draft1.809	LT 31.09	Assessment Instrument	The system shall provide the ability to export federally mandated assessment data in formats as required by jurisdictional authority.	2011	N				DC.1.5.1
Draft1.810	LT 31.10	Assessment Instrument	The system shall provide the ability to access, view, report, and display all previously completed federally mandated assessments.	2011	N				DC.1.5.1
Draft1.811	LT 31.11	Assessment Instrument	The system shall provide the ability to flag for inconsistencies between OASIS, Plan of Care, and treatment performed by providers.				R		Source is WG discussion.
Draft1.812	LT 31.12	Assessment Instrument	The system shall provide the ability to indicate date-sensitive MSA codes.	2011	NH				Source is WG discussion.
Draft1.813	LT 31.13	Assessment Instrument	The system shall provide the ability to generate a CMS 485.	2011	NH				Source is WG discussion.
Draft1.814	LT 31.14	Assessment Instrument	The system shall provide the ability to issue alerts when follow-up federally mandated assessments are due.	2011	N				Source is WG discussion.
Draft1.815	LT 31.15	Assessment Instrument	The system shall provide the ability to flag potential LUPA and PEP situations.				RH		Source is WG discussion.
Draft1.816	LT 31.16	Assessment Instrument	The system shall provide the ability to produce reports that allow for analysis of utilization and reimbursement.				R	For example, case mix, visits by HHRG, etc.	Source is WG discussion.
Draft1.817	LT 31.17	Assessment Instrument	The system shall provide the ability to track therapy visit thresholds from OASIS to actual.				RH		Source is WG discussion.
Draft1.818	LT 31.18	Assessment Instrument	The system shall provide the ability to add custom items to an assessment form.	2011	NH				Source is WG discussion.

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Draft1.819	LT 31.19	Assessment Instrument	The system shall provide the ability to incorporate skip logic during data entry in a federally mandated assessment.	2011	N				Source is WG discussion.
Draft1.820	LT 31.20	Assessment Instrument	The system shall have the ability to save a federally mandated assessment in incomplete form.	2011	N				
Draft1.821	LT 31.21	Assessment Instrument	The system shall provide the ability to prevent federally mandated assessment lock if an assessment is incomplete or unsigned, or displays incomplete fields.	2011	N			The intent of this criteria is to prevent the inappropriate lock of a federally mandated assessment.	Source is WG discussion.
Draft1.822	LT 32.01	Report generation	The system shall provide the ability to generate reports of clinical and administrative data using either internal or external reporting tools.	2011	N			Needed for pay for performance, quality improvement activities. All data that is entered in a structured format should be individually reportable.	AM 29.01, S.2.2
Draft1.823	LT 32.02	Report generation	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).	2011	N			Report format may be plain text. In Home Health this criterion helps to generate a 485.	AM 29.02, S.2.2
Draft1.824	LT 32.03	Report generation	The system shall provide the ability to generate reports regarding multiple patients (e.g. diabetes roster).	2011	N			Any disease registry might be included.	AM 29.03, S.2.2
Draft1.825	LT 32.04	Report generation	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).				R	Minimum demographic data are age and gender.	AM 29.04, S.2.2
Draft1.826	LT 32.05	Report generation	The system shall provide the ability to access reports outside the EHR application.	2011	N			For example, printed output, export to a file, etc.	AM 29.05, S.2.2
Draft1.827	LT 32.06	Report generation	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).				R		AM 29.06, S.2.2
Draft1.828	LT 32.07	Report generation	The system shall provide the ability to save report parameters for generating subsequent reports.				R		AM 29.07, S.2.2
Draft1.829	LT 32.08	Report generation	The system shall provide the ability to modify one or more parameters of a saved report specification when generating a report using that specification.				R	It is acceptable if a third-party reporting tool or application is used.	AM 29.08, S.2.2
Draft1.830	LT 33.01	Health record output	The system shall provide the ability to define one or more reports as the formal health record for disclosure purposes.	2011	N			This curtails the ability to 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.	AM 30.01, S.2.2.1
Draft1.831	LT 33.02	Health record output	The system shall provide the ability to generate hardcopy or electronic output of part or all of the individual patient's medical record.	2011	N				AM 30.02, S.2.2.1
Draft1.832	LT 33.03	Health record output	The system shall provide the ability to generate hardcopy and electronic output by date and/or date range.	2011	N			It is not required that output by date or date range includes items that are not date specific.	AM 30.03, S.2.2.1
Draft1.833	LT 33.04	Health record 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.				R	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.	AM 30.04, S.2.2.1

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Draft1.834	LT 33.05	Health record output	The system shall provide the ability to create hardcopy and electronic report summary information (procedures, medications, labs, immunizations, allergies, and vital signs).	2011	N			The report that's produced should be organized by section to make it easier to read.	AM 30.05, S.2.2.1
Draft1.835	LT 33.06	Health record output	The system shall provide the ability to support for disclosure management in compliance with HIPAA and applicable law.	2011	N			This criterion may be satisfied by providing the ability to create a free text note in the patient's record. More advanced functionality may be market differentiators or requirements in later years.	AM 30.06
Draft1.836	LT 33.07	Health record output	The system shall provide the ability to include patient identifying information, as well as time and date report printed, on each page of individual patient-specific reports generated.	2011	N				IP 19.02, S.2.2.1
Draft1.837	LT 34.01	Clinical research	The system shall provide the ability to present protocols for patients enrolled in research studies.			R			DC.2.2.3
Draft1.838	LT 34.02	Clinical research	The system shall provide the ability to maintain research study protocols.			R			DC.2.2.3
Draft1.839	LT 34.03	Clinical research	The system shall provide the ability to indicate whether a patient is enrolled in a clinical trial.			R		This should be captured as discrete data.	IP 19.09
Draft1.840	LT 35.01	Administrative	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.			R		Patient appointments could be doctor visits (regulated in NH), required nursing visits (MDS, OASIS, and supervisory) and ordered visits (home care only).	AM 28.01, S.1.6
Draft1.841	LT 35.02	Administrative	The system shall provide the ability to provide a list of financial and administrative codes.	2011	N			For example, ICD-9 CM, ICD-10 CM, SNOMED or CPT-4 codes.	AM 32.01, S.3.2.2
Draft1.842	LT 35.03	Administrative	The system shall provide the ability to select an appropriate CPT Evaluation and Management code based on data found in a clinical encounter.			R		May be accomplished via a link to another application.	AM 32.02, S.3.2.2
Draft1.843	LT 35.04	Administrative	The system shall provide the ability to provide assistance with selecting an appropriate CPT Evaluation and Management billing code based on codified clinical information in the encounter.			RS		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.	AM 32.03, S.3.2.2
Draft1.844	LT 36.01	Clinical decision support administration	The system shall provide the ability to update the clinical content or rules utilized to generate clinical decision support reminders and alerts.			R		CPT-4 codes and drug interactions are examples. Any method of updating would be acceptable. Content could be third party or provider-created.	AM 35.01, S.3.7.1
Draft1.845	LT 36.02	Clinical decision support administration	The system shall provide the ability to update clinical decision support guidelines and associated reference material.			R		Any method of updating would be acceptable. Content could be third party or provider-created.	AM 35.02, S.3.7.1
Draft1.846	LT 36.03	Clinical decision support administration	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).			R		An example is "patient refused."	FN 18.02
Draft1.847	LT 37.01	Confidentiality	The system shall provide the ability to document a patient's dispute with information currently in their chart.	2011	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, or 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.	AM 36.02, I.1.9
Draft1.848	LT 37.02	Confidentiality	The system shall provide the ability to identify certain information as confidential and only make that accessible by appropriately authorized users.	2011	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.	AM 36.04, I.1.9
Draft1.849	LT 37.03	Confidentiality	The system shall provide the ability to prevent specified user(s) from accessing a designated patient's chart.	2011	N			An example would be to block a user who has a personal relationship with a patient from accessing that patient's chart.	AM 36.05, I.1.9
Draft1.850	LT 37.04	Confidentiality	When access to a chart is restricted, the system shall provide the ability to appropriately authorized users to "break the glass" for emergency situations.			R			AM 36.06
Draft1.851	LT 37.05	Confidentiality	The system shall provide the ability to indicate when "break the glass" access to patient information occurred.			R			AM 36.08

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Draft1.852	LT 38.01	Data retention, availability and destruction	The system shall provide the ability to retain data until otherwise purged, deleted, archived, or otherwise deliberately removed.	2011	N				AM 37.01, I.2.1
Draft1.853	LT 38.02	Data retention, availability and destruction	The system shall provide the ability to archive health record information.			R		Archiving is used to mean information stored in a retrievable fashion without defining where or how it is stored.	AM 37.01, I.2.1
Draft1.854	LT 38.03	Data retention, availability and destruction	The system shall provide the ability to retrieve information that has been archived.			R		Retrieval does not imply restoration to current version of the software.	AM 37.03
Draft1.855	LT 39.01	Concurrent use	The system shall provide the ability for multiple users to interact concurrently with the EHR application.	2011	N				AM 40.01, Ontario 5.6.1.a
Draft1.856	LT 39.02	Concurrent use	The system shall provide the ability for concurrent users to simultaneously view the same record.	2011	N				AM 40.02, Ontario 5.6.1.a
Draft1.857	LT 39.03	Concurrent use	The system shall provide the ability for concurrent users to view the same clinical documentation or template.	2011	N				AM 40.03, Ontario 5.6.1.a
Draft1.858	LT 39.04	Concurrent use	The system shall provide the ability to maintain the integrity of clinical data during concurrent access.	2011	N			The intent of this criterion is to prevent users from simultaneously attempting to update a record with resultant loss of data.	AM 40.04, Ontario 5.6.1.a, I.1.9
Draft1.859	IO-LT 07.01	Laboratory	The system shall provide the ability to receive and store general laboratory results (including the ability to differentiate preliminary results and final results and the ability to process a corrected result) using the HL7 v.2.5.1 ORU message standard.			R		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 common test codes from the HEDIS subset. See LOINC.org for more about HEDIS.	IO-AM 07.01, HL7 v2.5.1, LOINC For more information please refer to the CCHIT 2011 Certification Interoperability Testing Guide MU.P1.G1 MU.P1.EP.O11
Draft1.860	IO-LT 07.02	Laboratory	The system shall provide the ability to receive and store microbiology laboratory results with organisms recorded as free-text.			R		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 common test codes from the HEDIS subset. Organisms recorded as free-text in 2011. See LOINC.org for more about HEDIS.	IO-AM 07.02, HL7 v2.5.1, LOINC For more information please refer to the CCHIT 2011 Interoperability Testing Guide MU.P1.G1 MU.P1.EP.O11
Draft1.861	IO-LT 07.04	Laboratory	The system shall provide the ability to receive and store microbiology laboratory results with sensitivity testing coded using LOINC.			R		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 common test codes from the HEDIS subset. Organisms recorded as free-text in 2011. See LOINC.org for more about HEDIS.	IO-AM 07.04, HL7 v2.5.1, LOINC For more information please refer to the CCHIT 2011 Certification Interoperability Testing Guide MU.P1.G1 MU.P1.EP.O11
Draft1.862	IO-LT 09.06	Medications / ePrescribing	The system shall provide the ability to send an electronic prescription to pharmacy.	2011	NS				IO-AM 09.06, Medication Management Interoperability Spec (HITSP v1.0 2008 IS07); NCPDP SCRIPT Standard v8.1 or higher (NEWRX) MU.P1.EP.O4
Draft1.863	IO-LT 09.09	Medications / ePrescribing	The system shall provide the ability to respond to a request for a refill sent from a pharmacy.			RS			IO-AM 09.09, Medication Management Interoperability Specification (HITSP v1.0 2008 IS07); NCPDP SCRIPT Standard 8.1 or higher (REFREQ and REFRES) MU.P1.EP.O4
Draft1.864	IO-LT 09.13	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.			RS		An essential first step prior to sending a query for medication history or formulary information directed at prescription drug coverage.	IO-AM 09.13, Medication Management Interoperability Specification (HITSP v1.0 2008 IS07) X12 270/271/ CORE Phase I Rules
Draft1.865	IO-LT 09.14	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.			RS		Usually preceded by a query for insurance eligibility to verify potential source of data.	IO-AM 09.14, Medication Management Interoperability Specification (HITSP v1.0 2008 IS07); NCPDP Formulary and Benefit Standard Implementation Guide v1.0
Draft1.866	IO-LT 09.15	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.			RS			IO-AM 09.15, NCPDP SCRIPT Standard v8.1 or higher (RXHREQ, RXHRES) / NDC codes

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Draft1.867	IO-LT 09.02	Clinical Documentation	The system shall provide the ability to display CCD documents, using a subset of the HITSP C32 specification for allergy content information, and file them as intact documents in the EHR.	2011	N			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).	IO-AM 09.02, HITSP IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v.2.5 Summary Documents Using HL7 Continuity of Care Document (CCD); C80 v1.1 - Clinical Document and Message Terminology; C83 v1.1 - CDA Content Modules; Section 2.2.2.2 Allergies and Other Adverse Reactions  MU.P3.G1 MU.P3.EP.O1
Draft1.868	IO-LT 11.13	Clinical Documentation	The system shall provide the ability to display CCD (HITSP C32) documents per HITSP IS107, Capability 119 Communicate Structured Documents, using a subset of the HITSP C32 specification for Results information and file them as intact documents in the EHR.	2011	N			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).	HITSP IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v.2.5 Summary Documents Using HL7 Continuity of Care Document (CCD) ; C80 v1.1 - Clinical Document and Message Terminology; C83 v1.1 - CDA Content Modules; Section 2.2.1.22 Diagnostic Results Section;  MU.P3.G1 MU.P3.EP.O1
Draft1.869	IO-LT 11.14	Clinical Documentation	The system shall provide the ability to display CCD (HITSP C32) documents per HITSP IS107, Capability 119 Communicate Structured Documents, using a subset of the HITSP C32 specification for <b>Condition</b> information and file them as intact documents in the EHR.	2011	N			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).	IO-AM 11.14, HITSP IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v.2.5 Summary Documents Using HL7 Continuity of Care Document (CCD) ; C80 v1.1 - Clinical Document and Message Terminology; C83 v1.1 - CDA Content Modules; Section 2.2.1.3 Problem List Section  MU.P3.G1 MU.P3.EP.O1
Draft1.870	IO-LT 09.05	Clinical Documentation	The system shall provide the ability to generate and format CCD documents with narrative sections and structured entries (discrete fields) per the:  HITSP IS03/C32 v2.3 Conditions and Allergy-coded module subset -OR- HITSP IS107/C32 v2.5 Allergy and Drug Sensitivities module subset.  The intent is to test the Required (R) fields for the C32 document.	2011	N				IO-AM 09.05, Summary Documents Using CCD Component (HITSP v2.3 C32) Consumer Empowerment Interoperability Specification (HITSP v3.0 IS03) Section 3.2.3.6 C32 "Creator-Conditions and Allergy-Coded Subset -OR- HITSP IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v.2.5 Summary Documents Using HL7 Continuity of Care Document (CCD); C80 v1.1 - Clinical Document and Message Terminology; C83 v1.1 - CDA Content Modules; Section 2.2.1.2 Allergies and Other Adverse Reactions  MU.P3.G1 MU.P3.EP.O1

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Draft1.871	IO-LT 11.16	Clinical Documentation	The system shall provide the ability to generate and format CCD (HITSP C32) documents with narrative sections and structured entries (discrete fields) per the:  HITSP IS03/C32 v2.3 Condition module -OR- HITSP IS107/C32 v2.5 Conditions Content Module	2011	N				IO-AM 11.16, Summary Documents using CCD Component (HITSP v2.3 C32); Consumer Empowerment Interoperability Specification (HITSP v3.0 IS03) Section 3.2.3.5 C32 Creator-Conditions and Allergy-Subset; HITSP C80 v1.0 Clinical Document and Message Terminology Component -OR- HITSP IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v2.5 Summary Documents Using HL7 Continuity of Care Document (CCD) ; C80 v1.1 - Clinical Document and Message Terminology; C83 v1.1 - CDA Content Modules; Section 2.2.1.3 Problem List Section
Draft1.872	IO-LT 11.01	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.	2011	N			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).	IO-AM 11.01, IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v2.5 Summary Documents Using HL7 Continuity of Care Document (CCD) ; C80 v1.1 - Clinical Document and Message Terminology; C83 v1.1 - CDA Content Modules; Section 2.2.2.1 Personal Information  MU.P3.G1 MU.P3.EP.O1
Draft1.873	IO-LT 11.04	Clinical Documentation	The system shall provide the ability to generate and format CCD documents with narrative sections and structured entries (discrete fields) and specified Terminology and value sets:  per the HITSP IS03 C32 v2.3 specification of the Registration Information module subset  -OR-  per the HITSP IS107 C32 v2.5 specification of the Registration Information module.	2011	N			Note: Within the Registration Coded subset, <b>Person Information and Information Source</b> content modules are Required; per the HITSP C32 specification, and all required [B] data elements within those modules will be tested. Provider, Insurance, Pregnancy, Advance Directive, and Comments modules are optional. These will not be tested by CCHIT for 2011 Certification. Language and Support are "required if known" content modules. These also will not be tested by CCHIT in 2011. It is <b>strongly encouraged</b> to generate as complete a CCD as possible, including R2 and O modules and data elements, in order to provide a meaningful patient summary that includes context for the medications and allergies, but for 2011 CCHIT will only test those content modules that are always Required by HITSP C32.	IO-AM 11.04, Summary Documents Using CCD Component (HITSP v2.3 C32) Consumer Empowerment Interoperability Specification (HITSP v3.0 IS03) Section 3.2.3.2 C32 "Creator-Registration-Coded Subset" -or- IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v2.5 Summary Documents Using HL7 Continuity of Care Document (CCD) ; C80 v1.1 - Clinical Document and Message Terminology; C83 v1.1 - CDA Content Modules; Section 2.2.2.1 Personal Information  2011- Generate HITSP C32 Document with the required use of coded Terminologies as specified in the C32 for registration information  MU.P3.G1 MU.P3.EP.O1
Draft1.874	IO-LT 11.05	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	2011	N			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).	IO-AM 11.05, IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v2.5 Summary Documents Using HL7 Continuity of Care Document (CCD); C80 v1.1 - Clinical Document and Message Terminology; C83 v1.1 - CDA Content Modules; Section 2.2.1.12 Medications

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Draft1.875	IO-LT 11.08	Clinical Documentation	The system shall provide the ability to generate and format CCD documents with narrative sections and structured entries (discrete fields) and specified terminology and value sets for medications per the.  HITSP IS03/C32 v2.3 specification of the Medication and Immunization History-coded module subset (not including Immunizations)  -OR-  HITSP IS107 C32 v2.5 specification of the Medication section  For 2011 LTPAC CCHIT will not be testing the ability to codify the Coded Product Name using either NDC or RxNorm values	2011	N				IO-AM 11.08, MU P3.G1, MU P3.IP.01 Summary Documents Using CCD Component (HITSP v2.3 C32) Consumer Empowerment Interoperability Specification (HITSP v3.0 IS03) Section 3.2.3.4 C32 "Creator-Medication and Immunization History-Coded Subset" -OR- IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v2.5 Summary Documents Using HL7 Continuity of Care Document (CCD); C80 v1.1 - Clinical Document and Message Terminology; C83 v1.1 - CDA Content Modules; Section 2.2.1.12 Medications  2011- Generate HITSP C32 Document with the required use of coded Terminologies as specified in the C32 for medication history information
Draft1.876	IO-LT 12.01	Document Exchange	The system shall perform the required transactions for the <b>Document Source Actor</b> as specified by the IHE ITI Technical Framework (Rev 5) specification using either XDS.a or XDS.b for 2011 Certification.	2011	O			The Document Source Actor is the producer and publisher of documents. It is responsible for sending documents to a Document Repository Actor. It also supplies metadata to the Document Repository Actor for subsequent registration of the documents with the Document Registry Actor.	IO-AM 12.01, HITSP IS03 Consumer Empowerment and Access to Clinical Information via Networks v.3.0; IHE IT Infrastructure Technical Framework Revision 5.0 IHE Cross-Enterprise Document Sharing (XDS) integration profile Manage sharing of documents Transaction Package (HITSP v2.2 2007 TP13) XDS.a - IHE XDS ITI-15: Provide & Register Document Set XDS.b - IHE XDS ITI-41: Provide & Register Document Set - b
Draft1.877	IO-LT 12.02	Document Exchange	The system shall perform the required transactions for the <b>Document Consumer Actor</b> as specified by the IHE ITI Technical Framework (Rev 5) specification using either XDS.a or XDS.b for 2011 Certification.	2011	O			The Document Consumer Actor queries a Document Registry Actor for documents meeting certain criteria, and retrieves selected documents from one or more Document Repository actors.	IO-AM 12.02, HITSP IS03 Consumer Empowerment and Access to Clinical Information via Networks v.3.0; IHE IT Infrastructure Technical Framework Revision 5.0 IHE Cross-Enterprise Document Sharing (XDS) integration profile Manage sharing of documents Transaction Package (HITSP v2.2 2007 TP13) XDS.a - IHE XDS ITI-18: Registry Stored Query, followed by IHE XDS ITI-17: Retrieve Document or XDS.b - IHE XDS ITI-18: Registry Stored Query, followed by IHE XDS ITI-43: Retrieve Document Set
Draft1.878	IO-LT 12.05	Document Exchange	The system shall support either Patient Identity Source plus PIX Consumer and/or Patient Demographics Query.	2011	O			This criteria refers to coordination of patient identification between an EHR and another system.	IO-AM 12.05, HITSP IS03 Consumer Empowerment and Access to Clinical Information via Networks v.3.0; IHE IT Infrastructure Technical Framework Revision 5.0; Patient ID Cross-Referencing Transaction Package (HITSP v2.0 2007 TP22); Patient Demographic Query Transaction (HITSP v2.0 2007 T23)
Draft1.879	SC 01.01	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.	2011	N				SC 01.01, ISO 17799: 9.1.1.2.b; HIPAA: 164.312(a)(1); 164.308(a)(3)(1) HITSP/TP20 NIST SP 800-53: AC-6 LEAST PRIVILEGE; AC-5 SEPARATION OF DUTIES  MU.P5.G1
Draft1.880	SC 01.02	Access Control	The system shall provide the ability for authorized administrators to assign restrictions or privileges to users/groups.	2011	N				SC 01.02, Canadian: Alberta 4.1.3 (EMR); ISO 15408 CC SFR: FMT_MSA; NIST SP 800-53: AC-56 LEAST PRIVILEGE; AC-5 SEPARATION OF DUTIES HIPAA: 164.312(a)(1); 164.308(A)(3)(1); HITSP/TP20  MU.P5.G1

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Draft1.881	SC 01.03	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.)	2011	N				SC 01.03, Canadian: Ontario 5.3.12.e (System Access Management); ISO 15408 CC SFR: FDP_ACC, FMT_MSA; ASTM: E1985-98; NIST SP 800-53: AC-3 ACCESS AND INFORMATION FLOW CONTROL; SC-3 SECURITY FUNCTION ISOLATION; HIPAA: 164.312(a)(1); 164.308(A)(3)(1); HITSP/TP20  MU.P5.G1
Draft1.882	SC 01.04	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.	2011	N				SC 01.04, HIPAA: 164.308(a)(4)(ii)(C); 164.308(a)(3)(i)(C); HITSP/TP20  MU.P5.G1
Draft1.883	SC 02.01	Audit	The system shall allow an authorized administrator to set the inclusion or exclusion of auditable events in SC 02.03 based on organizational policy and operating requirements/limits.	2011	N				SC 02.01, ISO 15408 CC SFR: FAU_SEL; HIPAA 164.312(b); 164.308 (a)(1)(ii)(A), (D); Federal Register Response pages 8347, 8355; NIST SP 800-53 AU-2 AUDITABLE EVENTS (Organization Defined - Based on Risk Assessment) HITSP/TP15  MU.P5.G1
Draft1.884	SC 02.02	Audit	The system shall support logging to a common audit engine using the schema and transports specified in the Audit Log specification of IHE Audit Trails and Node Authentication (ATNA) Profile.			R			SC 02.02, NIST SP 800-92/SP 800-92, HITSP T15 HIPAA 164.312(a)(1); 164.312(b); 164.308 (a)(1)(ii)(A) and (D);
Draft1.885	SC 02.03	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 those listed in the <i>Appendix Audited Events</i> . 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.	2011	N				SC 02.03, ISO 15408 CC SFR: FAU_GEN; NIST SP 800-53: AU-2 AUDITABLE EVENTS; HIPAA: 164.312(b); 164.312(1); 164.308 (a)(1)(ii)(A) and (D); HITSP/TP15  MU.P5.G1
Draft1.886	SC 02.04	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.	2011	N				SC 02.04, ISO 15408 CC SFR: FAU_GEN; NIST SP 800-53: AU-3 CONTENT OF AUDIT RECORDS, AU-10 NON-REPUDIATION; HIPAA: 164.312(b); HITSP/TP15  MU.P5.G1
Draft1.887	SC 02.05	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).	2011	N			Assignable to third party.	SC 02.05, ISO 15408 CC SFR: FAU_SAR; NIST SP 800-53: AU-7 AUDIT REDUCTION AND REPORT GENERATION; HIPAA: 164.312(b); HITSP/TP15  MU.P5.G1
Draft1.888	SC 02.06	Audit	The system shall be able to support time synchronization using NTP/SNTP, and use this synchronized time in all security records of time.	2011	N			Assignable to third party.	SC 02.06, ISO 15408 CC SFR: FPT_STM; NIST SP 800-53: AU-8 TIME STAMPS; HITSP/TP16 HIPAA: 164.312(b)  MU.P5.G1
Draft1.889	SC 02.07	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.			R			SC 02.07, ISO 15408 CC SFR: FPT_STM; NIST SP 800-53: AU-8 TIME STAMPS; HITSP/TP15 HIPAA: 164.312(b)  MU.P5.G1

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Draft1.890	SC 02.08	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.	2011	N			Assignable to third party.	SC 02.08, ISO 15408 CC SFR: FAU_SAR, FAU_STG; NIST SP 800-53: AU-9 PROTECTION OF AUDIT INFORMATION; HIPAA: 164.312(a)(1); HITSP/TP15 MU.P5.G1
Draft1.891	SC 03.01	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.	2011	N			Assignable to third party.	SC 03.01, Canadian: Alberta 1.1; ISO 15408 CC SFR: FIA_UAU, FIA_UID; NIST SP 800-53: IA-2 USER IDENTIFICATION AND AUTHENTICATION; HIPAA: 164.312(d) MU.P5.G1
Draft1.892	SC 03.02	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.	2011	N			Assignable to third party.	SC 03.02 Canadian: Alberta 7.3.12 (Security) Canadian Ontario 5.3.12.b (System Access Management); ISO 15408 CC SFR: FIA_SOS, FIA_UAU, FIA_UID; ASTM: E1987-98; NIST SP 800-53: IA-2 USER IDENTIFICATION AND AUTHENTICATION (no strength of password); ISO 17799: 9.3.1.d; HIPAA: 164. MU.P5.G1
Draft1.893	SC 03.03	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.	2011	N			Assignable to third party.	SC 03.03, Canadian: Alberta 7.3.14 (Security) Canadian Ontario 5.6.12.a (Workstation Security); ISO 15408 CC SFR: FTA_SSL, FMT_SAE; NIST SP 800-53: AC-7 UNSUCCESSFUL LOGIN ATTEMPTS; AC-11 SESSION LOCK; AC-12 SESSION TERMINATION HIPAA: 164.312(a)(1); 164.312(a)(2)(iii) MU.P5.G1
Draft1.894	SC 03.04	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).	2011	N			Assignable to third party.	SC 03.04, Canadian: Ontario 5.3.12.c (System Access Management); ISO 15408 CC SFR: FIA_AFL, FMT_SAE; NIST SP 800-53: AC-6 UNSUCCESSFUL LOGIN ATTEMPTS; AC-11 SESSION LOCK; ISO 17799: 9.3.1.e, 9.5.2.e; HIPAA: 164.312(a)(1); 164.308(a)(5)(ii)(C); 164.308(a)(6) MU.P5.G1
Draft1.895	SC 03.05	Authentication	When passwords are used, the system shall provide an administrative function that resets passwords.	2011	N			Assignable to third party.	SC 03.05, ISO 15408 CC SFR: FMT_MTD; ISO 17799: 9.2.3.b, (9.3.1.i); HIPAA: 164.312(d); 164.308(5)(ii)(D) MU.P5.G1
Draft1.896	SC 03.06	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.	2011	N			Assignable to third party.	SC 03.06, ISO 15408 CC SFR: FMT_MTD; ISO 17799: 9.2.3.b, (9.3.1.i); HIPAA: 164.312(d); 164.308(5)(ii)(D) MU.P5.G1
Draft1.897	SC 03.07	Authentication	The system shall provide only limited feedback information to the user during the authentication.	2011	N			Assignable to third party.	SC 03.07, ISO 15408 CC SFR: FIA_UAU; NIST SP 800-53: IA-6 AUTHENTICATOR FEEDBACK; HIPAA: 164.312(d); 164.308(5)(ii)(D) MU.P5.G1
Draft1.898	SC 03.08	Authentication	The system shall support case-insensitive usernames that contain typeable alpha-numeric characters in support of ISO-646/ECMA-6 (aka US ASCII).	2011	N			Assignable to third party.	SC 03.08, ISO 15408 CC SFR: FMT_MTD; HIPAA: 164.312(a)(2)(i) MU.P5.G1
Draft1.899	SC 03.09	Authentication	When passwords are used, the system shall allow an authenticated user to change their password consistent with password strength rules (SC 03.02).	2011	N			Assignable to third party.	SC 03.09, ISO 15408 CC SFR: FMT_MTD; HIPAA: 164.308(a)(5)(ii)(D) MU.P5.G1

UNIQUE ID	Criteria #	Category	Criteria	Year introduced or last modified	2011	2013	2015-	Comments	Criteria Reference
					Certification	Roadmap	Roadmap		
Draft1.900	SC 03.10	Authentication	When passwords are used, the system shall support case-sensitive passwords that contain typeable alpha-numeric characters in support of ISO-646/ECMA-6 (aka US ASCII).	2011	N			Assignable to third party.	SC 03.10, Canadian: Ontario 5.3.12 (b); NIST SP 800-63; HIPAA: 164.308(a)(5)(ii)(D); MU.P5.G1
Draft1.901	SC 03.12	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").	2011	N			Assignable to third party.	SC 03.12, ISO 15408 CC SFR: FMT_MTD; ISO 17799 9.5.4.f; HIPAA 164.312(d); 164.308(a)(5)(ii)(D); NIST SP 800-53: IA5 AUTHENTICATOR MANAGEMENT; MU.P5.G1
Draft1.902	SC 04.01	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).	2011	N				SC 04.01, ISO 15408 CC SFR: AGD_ADM; HIPAA: 164.308(a)(5)(i)(B)
Draft1.903	SC 04.02	Documentation	The system shall include documentation that explains system error or performance messages to users and administrators, with the actions required.	2011	N				SC 04.02, ISO 15408 CC SFR: AGD_ADM; HIPAA: 164.312(c)
Draft1.904	SC 04.03	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).	2011	N				SC 04.03, ISO 15408 CC SFR: AGD_ADM; NIST SP 800-53 CM-2; HIPAA: 164.312(c); 164.306(A)(1)
Draft1.905	SC 04.04	Documentation	The system shall include documented procedures for product installation, start-up and/or connection.	2011	N				SC 04.04, ISO 15408 CC SFR: ADO_IGS; HIPAA: 164.312(c)
Draft1.906	SC 04.05	Documentation	The system shall include documentation of the minimal privileges necessary for each service and protocol necessary to provide EHR functionality and/or serviceability.	2011	N				SC 04.05, NIST SP 800-53 AC-6 SEPARATION OF DUTIES; CM-7 Least Functionality; HIPAA: 164.312(a)(1); 164.312(a)(2)
Draft1.907	SC 04.06	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.).	2011	N				SC 04.06, Canadian: Alberta 7.3.17 (Security); ISO 15408 CC SFR: FPT_TST; ISO 15408 CC SFR: AGD_ADM; NIST SP 800-53 SI-3 MALICIOUS CODE PROTECTION; HIPAA: 164.308(a)(5)(i)(B)
Draft1.908	SC 04.07	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.	2011	N				SC 04.07, ISO 15408 CC SFR: AGD_ADM; HIPAA: 164.310(a)(2)
Draft1.909	SC 04.08	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).	2011	N				SC 04.08, ISO 15408 CC SFR: AGD_ADM; NIST SP 800-53 AC-5 CM-6; NIST SP 800-70; HIPAA 164.312(a)(1)
Draft1.910	SC 04.09	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.	2011	N				SC 04.09, ISO 15408 CC SFR: AGD_ADM; HIPAA: 164.312(d)

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Draft1.911	SC 04.10	Documentation	The system shall include documentation available to the customer that provides guidelines for configuration and use of the 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.	2011	N			Assignable to third party.	SC 04.10, ISO 15408 CC SFR: AGD_ADM; HIPAA: 164.312(a) to 164.312(e)
Draft1.912	SC 05.01	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.	2011	N				SC 05.01, ISO 15408 CC SFR: ADO_DEL; HIPAA: 164.308(a)(5)(ii)(B); MU.P5.G1
Draft1.913	SC 05.02	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.).	2011	N			Assignable to third party.	SC 05.02, ISO 15408 CC SFR: FPT_RCV; HIPAA: 164.312(c)(1); MU.P5.G1
Draft1.914	SC 06.01	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) and an open protocol such as TLS, SSL, IPsec, XML encryptions, or S/MIME or their successors.	2011	N			Assignable to third party.	SC 06.01, Canadian: Alberta 7.4.6.2 & 8.4.6.2 (Technical); ISO 15408 CC SFR: FCS_COP, FIPS 140-2; NIST SP 800-53: SC-13 CRYPTOGRAPHIC OPERATIONS; HIPAA: 164.312(e)(1); 164.312(a)(2)(iv) HITSP T17; FIPS PUB 140-2; MU.P5.G1
Draft1.915	SC 06.02	Technical Services	When passwords are used, the system shall not display passwords while being entered.	2011	N			Assignable to third party.	SC 06.02, ISO 15408 CC SFR: FPT_ITC; ISO 17799 9.2.3; HIPAA: 164.312(a)(1); MU.P5.G1
Draft1.916	SC 06.03	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	2011	N			Assignable to third party.	SC 06.03, ISO 15408 CC SFR: AGD_ADM; HITSP/TP17; HIPAA: 164.312(e)(1); 164.312(a)(2)(iv) MU.P5.G1
Draft1.917	SC 06.04	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.	2011	N			Assignable to third party.	SC 06.04, ISO 15408 CC SFR: FPT_RCV; FIPS 140-2; SP800-53: SC-13 CRYPTOGRAPHIC OPERATIONS; HIPAA: 164.312(e)(1); HITSP T17; MU.P5.G1
Draft1.918	SC 06.05	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).	2011	N			Assignable to third party.	SC 06.05, ISO 15408 CC SFR: FPT_RCV; HITSP T17; HIPAA: 164.312(d); 164.312(c)(1); MU.P5.G1
Draft1.919	SC 06.06	Technical Services	The system, when storing PHI on any device intended to be portable/removable (e.g. thumb-drives, CD-ROM, PDA, Notebook), shall support use of a standards based encrypted format using triple-DES (3DES).	2011	N				SC 06.06, FIPS 140-2; ISO 15408 CC SFR: FCS_COP; OMB M-06-16, SP800-53: AC-19; HITSP T33; HIPAA: 164.312(e)(2)(ii); FIPS PUB 140-2; MU.P5.G1
Draft1.920	SC 06.07	Technical Services	The system, prior to access to any PHI, shall display a configurable warning or login banner (e.g. "The system should only be accessed by authorized users"). In the event that a system does not support pre-login capabilities, the system shall display the banner immediately following authorization.	2011	N			Assignable to third party.	SC 06.07, CC 2.1 L4 TOE access banners (FTA_TAB); CC 3.0 FIA_TIN.1 Advisory warning message; NIST SP 800-53 AC-8 System Use Notification; HIPAA: 164.308(a)(5)(i); 164.308(a)(5)(ii); MU.P5.G1
Draft1.921	SC 08.01	Backup/Recovery	The system shall be able to generate a backup copy of the application data, security credentials, and log/audit files.	2011	N			Assignable to third party.	SC 08.01, Canadian: Alberta 7.3.16 (Security); ISO 15408 CC SFR: FDP_ROL, FPT_RCV; HIPAA: 164.310(d)(1); MU.P5.G1

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Draft1.922	SC 08.02	Backup/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.	2011	N			Assignable to third party.	SC 08.02, Canadian: Alberta 7.3.18.9 (Security); ISO 15408 CC SFR: FAU_GEN; NIST SP 800-53: AU-2 AUDITABLE EVENTS; HIPAA: 164.310(d)(1) MU.P5.G1
Draft1.923	SC 08.03	Backup/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.	2011	N			Assignable to third party.	SC 08.03, Canadian: Alberta 7.4.2.5 (Technica+D11); ISO 15408 CC SFR: FDP_ROL; HIPAA: 164.310(d)(1) MU.P5.G1

**Appendix Audited Events**

1. start/stop
2. user login/logout
3. session timeout
4. account lockout
5. patient record created/viewed/updated/deleted
6. scheduling
7. query
8. order
9. node-authentication failure
10. signature created/validated
11. PHI export (e.g. print)
12. PHI import
13. security administration events
14. backup and restore