

Primary Care EMR Baseline Requirements 5.0

Requirements

October 10, 2019

Document Version & Status: 1.1 - Final



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1. INTRODUCTION

The purpose of this document is to describe a common set of functional and non-functional requirements that are fundamental to an EMR Offering used in a primary care setting.

Some of the functional requirements refer to the Ontario Ministry of Health and Long-Term Care (MOHLTC) guidelines. Ministry guidelines are available through various sources. These include:

- <http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/>
- <http://www.health.gov.on.ca/>

OntarioMD will make reasonable efforts to post information received from the MOHLTC on its web site(s), however, vendors are responsible for obtaining the necessary and most current information to continuously meet the baseline EMR requirements. OntarioMD shall not be responsible for the accuracy of the website links that are contained in this document or for any information contained on such websites. Respondents MUST contact the appropriate party to access the required information if links to these websites are no longer available or if there is any doubt about accuracy or currency.

Functional requirements MUST be in line with all legal requirements under:

- Ontario Regulation 114/94 (*Medicine Act*, 1991)
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91m30_e.htm

and all policies (including updates) published by the

- The College of Physicians and Surgeons of Ontario's (CPSO) – including the policy on Medical Records.
<http://www.cpso.on.ca/Physicians/Policies-Guidance/Policies>

This policy references various other legislative requirements, including those that may apply depending on the context within which a physician is practicing. Medical records are also a fundamental component of regulatory functions carried out by the CPSO under the authority of the *Regulated Health Professions Act*, 1991.

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm

Scope of the Primary Care EMR Baseline Requirements

The Primary Care EMR Baseline Requirements address requirements in each of the following categories:

Functional Requirements

- Demographic Management
- Electronic Medical Record (“EMR”) Management
- Immunization Management
- Medication Management
- Lab Test Management
- External Document Management
- Cumulative Patient Profile (“CPP”) Management
- Encounter Documentation
- Schedule Management
- Referral Management
- Reporting, Query and Communications
- Workflow Management
- Billing Management
- System Access Management
- Interface Requirements

Non-functional Requirements

- Data Management
- Auditing and Logging
- Implementation Support
- Licensing
- Privacy
- Security

Related Documents

The following table lists all documents related to or referenced in this specification.

DOCUMENT NAME	VERSION	DATE	PUBLISHING ORGANIZATION	LINK
Server Hardening Checklist	N/A	2011	OntarioMD	https://www.ontariomd.ca/portal/server.pt/community/ontario_emr_specifications/historical_documents
OMA Physician's Guide to Third-Party & Other Uninsured Services	N/A	Jan 2017	Ontario Medical Association	This is a "members only" document found under the heading "Billing and Agreements": https://www.oma.org/
CPSO Policies - Medical Records	N/A	May 2012	CPSO	https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Records
MOHLTC Guidelines <ul style="list-style-type: none"> • Preventive Care • Chronic Disease Management • Primary Care Agreements 	Various	Various	MOHLTC	http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/
Technical Specifications – Interface to Health Care Systems	5.0	Nov 2017	MOHLTC	http://www.health.gov.on.ca/en/pro/publications/ohip/
OHIP Fee Schedule Master	N/A	Dec 2015	MOHLTC	http://www.health.gov.on.ca/english/providers/program/ohip/sob/schedule_master.html

DOCUMENT NAME	VERSION	DATE	PUBLISHING ORGANIZATION	LINK
Health Card Validation (HCV) Reference Manual	1.0	May 2017	MOHLTC	http://www.health.gov.on.ca/en/pro/publications/ohip/
Processing Enrolment/Consent Forms Reference Manual For Primary Care Groups	N/A	N/A	MOHLTC	http://www.health.gov.on.ca/english/providers/pub/primarycare/proces_enrolment/proces_enrolment_mn.html
OLIS Nomenclature	Various	Various	eHealth Ontario	https://ehealthontario.on.ca/en/olis-nomenclature
Laboratory Requisition	2019/05	2019	MOHLTC	http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/sbforms.nsf/FormDetail?OpenForm&ACT=RDR&TAB=PROFILE&ENV=WWE&NO=014-4422-84

2. SPECIFICATION TRACEABILITY

Highlights of Changes

Core EMR Specification Section 1: EMR Baseline Requirements v4.2 was used as the basis of this specification.

TYPE	# OF REQUIREMENTS 5.0	# OF REQUIREMENTS 4.2	# OF REQUIREMENTS 4.1
New Requirements	2	3	30
Updated Requirements	12	24	20
Previous Requirements	183	168	148
Retired Requirements	0	2	N/A
Total Number of Requirements	197	195	198

* NOTE: Due to splitting and/or merging requirements defined in a previous specification, the “Total Number of Requirements” in a newer version is not to be calculated based on the “Total Number of Requirements” in a previous specification version.

For traceability, the content of the Core EMR Specification Section 1: EMR Baseline Requirements v4.2 was split into two separate specifications:

- Discrete data element requirements were moved into the EMR Core Data Set 5.0 Specification.
- EMR Offering functional requirements were moved into the EMR Primary Care Baseline Requirements 5.0 Specification.

3. BASELINE EMR REQUIREMENTS

The following terms and abbreviations are defined and shall be applied to all tables in this section:

Support:

M = Mandatory. EMR Offerings certified for this specification **MUST** support this requirement

O = Optional. EMR vendors **MAY** choose to support this requirement in their certified EMR Offering

Status:

N = New requirement for this EMR Specification version

P = Previous EMR requirement

U = Updated from the previous EMR Specification version

R = Retired from the previous version

OMD #:

A unique identifier that identifies each requirement within OntarioMD's EMR Requirements Library

CONFORMANCE LANGUAGE

The following definitions of the conformance verbs are used in this document:

- **SHALL/MUST**: Required/Mandatory
- **SHOULD**: Best Practice/Recommendation
- **MAY**: Acceptable/Permitted

The tables that follow contain column headings named: 1) "Requirement," which generally contain a high-level requirement statement; and 2) "Guidelines," which contain additional instructions or detail about the high-level requirement. The text in both columns is considered requirement statements.

Demographic Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR01.01	Maintains patient demographic data for rostered patients	Refer to the EMR Core Data Set Specification for patient demographic data elements.	M	P
EMR01.02	Supports the assignment of a patient to the physician roster	Refer to the EMR Core Data Set Specification for physician roster data elements.	M	P
EMR01.03	Maintains the current and historical enrolment of a patient to a physician	<p>Refer to the EMR Core Data Set Specification for patient enrolment history data elements.</p> <p>The definitive patient enrolment to a physician used for payment is kept by the Ministry of Health and Long-Term Care, not by the EMR Offering.</p> <p>The EMR user MUST be able to update the current and historical enrolment information.</p> <p>Patients are enrolled to a specific physician within a Physician Group, not to the Physician Group as a whole.</p> <p>Patients rostered to a physician can be either enrolled or non-enrolled.</p> <p><i>For more information Refer to "Processing Enrolment/Consent Forms Reference Manual For Primary Care Groups" in the Related Documents section.</i></p>	M	P
EMR01.04	Maintains multiple contacts	<p>Refer to the EMR Core Data Set Specification for patient contact data elements.</p> <p>A contact is a person named by the patient as someone who should be contacted in specific situations.</p> <p>At a minimum, the EMR Offering MUST support two contacts per patient.</p> <p>Each contact MUST support multiple contact purposes/roles, including Substitute Decision Maker and Emergency Contact.</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR01.05	Provides an automated method of identifying and preventing duplicate patient records	<p>The EMR Offering MUST provide a method of preventing the creation of duplicate patient records.</p> <p>Duplicate records are identified by a name match, or by a health card number match. Health card number version codes MUST be excluded from the matching function. A health card number with a different version code should be considered the same patient record.</p>	M	P
EMR01.06	Supports merging of duplicate patient records	<p>Merging of patients refers to the merging of the entire patient medical record (not only patient demographics).</p> <p>Merging of duplicate records is a manual function controlled by the EMR user.</p> <p>Automatic merging of duplicate records is not an acceptable solution.</p> <p>Prior to merging, the EMR user MUST be notified of the permanence of the action and given an opportunity to confirm the merging of duplicate patient records.</p> <p>There is no requirement to undo the merge.</p>	M	P
EMR01.07	Provides a means of access to the record of each patient by the patient's name and if the patient has an Ontario health card number by the health number	Based on Ontario Regulation 114/94, Section 20 (2).	M	P
EMR01.08	Maintains demographic data for providers	Refer to the EMR Core Data Set Specification for provider demographic data elements.	M	P

Electronic Medical Record (“EMR”) Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR02.01	Maintains ongoing health conditions, medical problems and diagnoses	Refer to the EMR Core Data Set Specification for ongoing health conditions, medical problems and diagnoses data elements.	M	P
EMR02.02	Maintains past medical and surgical history	Refer to the EMR Core Data Set Specification for past medical and surgical history data elements.	M	P
EMR02.03	Maintains allergy and adverse reaction data	Refer to the EMR Core Data Set Specification for allergy and adverse reaction data elements.	M	P
EMR02.04	Maintains family medical history	Refer to the EMR Core Data Set Specification for family medical history data elements.	M	P
EMR02.05	Maintains medical alerts and special needs	Refer to the EMR Core Data Set Specification for alerts and special needs data elements.	M	P
EMR02.06	Maintains immunization data	Refer to the EMR Core Data Set Specification for immunization data elements.	M	P
EMR02.07	Maintains risk factor data	Refer to the EMR Core Data Set Specification for risk factor data elements.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR02.08	Maintains care element data	<p>Refer to the EMR Chronic Disease Management Specification for chronic disease data elements.</p> <p>Refer to the EMR Core Data Set Specification for generic care data elements.</p>	M	P
EMR02.09	Maintains a record of preventive care/screening activities	<p>Must maintain the name of the preventive care/screening activity and the date it was performed.</p> <p>Additional fields (such as due dates, notes, etc.) are allowed. Preventive care and screening activities include (but are not limited to): Annual Physical exam, Influenza immunization, Mammography screening, Colorectal cancer screening, Pap Smear, Obesity screening, Tobacco use screening, Pre-natal checkup.</p>	M	P
EMR02.10	Preventive care/screening activities MUST automatically become visually distinct when past due in the patient chart	<p>Cannot be a work queue item. Must be visible within the EMR Offering.</p> <p>Can be for any health maintenance activity.</p>	M	P
EMR02.11	Provides the ability to modify the medical record of a patient to ensure accuracy in accordance with CPSO Policy Statement on Medical Records	<p>The intent of the requirement is to ensure accurate information informs care decisions and changes to the medical record are documented.</p> <p>Any information modified within the medical record MUST be available for review. The record MUST also indicate who made the change, and when the change was made.</p> <p>This may be available within the EMR Offering audit trail.</p> <p>The EMR vendor is required to conform to all subsequent releases of the CPSO Medical Records Policy.</p> <p>Refer to the "CPSO Medical Records Policy: https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Records.</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR02.12	Provides the EMR user with the ability to know the status of the EMR data on a past date	<p>At a minimum, the ability to know the status of past EMR data applies to the following data categories:</p> <ul style="list-style-type: none"> - Ongoing Health Conditions data - Past Medical and Surgical History data - Allergy and Adverse Reaction data - Family Medical History data - Alerts and Special Needs data - Immunization data - Risk Factors data - Care Elements data <p>EMR users MUST be able to identify which information was known at the time a medical decision was made.</p> <p>Searching through the audit trail in order to find the status of patient data on a particular date DOES NOT satisfy the requirement.</p>	M	P

Immunization Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR03.01	Provides the capability to print an immunization summary for a patient	<p>Immunization Summary is meant to reproduce the information which would be on the Ontario Immunization Record (Yellow Card) and should be consistent with the content.</p> <p>Immunization Summary includes:</p> <ul style="list-style-type: none"> - Patient Name - Patient Date of Birth - Patient Ontario Health Card Number - Complete list of Patient's Immunizations - Immunization Date - Name of Primary Physician <p>The name of the primary physician in this context is the name of the physician accountable for administering the specific vaccine listed in the summary. As such, there may be more than one physician name listed if the patient had vaccinations administered by different physicians.</p>	M	P
EMR03.02	Immunization data entered through EMR data fields is integrated across the EMR Offering.	<p>EMR user should not be forced to re-enter data.</p> <p>Requiring the EMR user to re-enter immunization data in order to maintain Preventive Care, Chronic Disease Management, Reporting of Diabetes or any other current requirements involving immunization data is not an acceptable solution.</p>	M	P
EMR03.02	EMR Offerings that use a drug database to record an administered immunization MUST be able to automatically fill in the Immunization Type based on the selected Immunization Name and/or the Immunization Code.	This requirement was previously embedded in the requirement for Immunization Type (DE08.003).	M	P

Medication Management

For the purposes of this section, the following terms are defined:

- Current Medications – Medications that are part of the patient’s treatment plan. This includes all active long-term and active short-term medications at the time of viewing the record.
- Long-term Medications - A medication which is expected to be continued beyond the present order and which the patient should be assumed to be taking unless explicitly stopped (also referred to as Continuous/Chronic). These are medications which the prescriber has identified as a part of the patient's ongoing treatment plan.
- Short-term Medications – A medication which the patient is only expected to consume for the duration of the current order and which is not expected to be renewed (also referred to as Acute). These are medications the prescriber has not identified as part of the patient’s long-term treatment plan.
- Past Medications – Medications which are no longer part of the patient’s treatment plan.
- PRN - A medication which the patient will consume intermittently based on the behaviour of the condition for which the medication is indicated (also referred to as “As Needed”). Applies to both Long-term and Short-term Medications.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR04.01	Provides the ability to create patient prescription records	Refer to the EMR Core Data Set Specification for medication data elements. The prescription record provides the ability to identify if a medication was/is prescribed by both an internal and external physician, such as a specialist, including first and last name. Prescriptions may be either new or a record of a past prescription.	M	P
EMR04.02	Maintains complete documentation of patient medications including: - medications ordered by other health care providers; - over-the-counter medications including herbal and nutritional supplements; and - past and current medications - active and inactive prescriptions	It is important to distinguish that there is a difference between the status of a medication in the treatment plan and the status of a prescription for that medication.	M	P
EMR04.03	Provides the ability to create a prescription for a drug not in the out-of-box drugs list (e.g., for a compound script).	The EMR Offering MUST also have the capability to add the drug to the medications list for the patient.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR04.04	Supports creation of an EMR user-defined medication list	EMR Offering to allow the creation of the EMR user's pre-defined list based on physician or condition.	M	P
EMR04.05	The EMR Offering provides the ability for a physician to print a prescription for a patient.	<p>Printed prescription MUST be able to include:</p> <ul style="list-style-type: none"> - physician information (name, address, phone number) - patient information (name, address, phone number) - name of medication - strength and strength unit - form - dosage - frequency - duration and/or quantity - refills - refill duration and/or refill quantity - start date - notes to pharmacist <p>It is acceptable that prescriptions are printed to a standard 8.5 x 11 sheet of paper.</p> <p>If prescription spans multiple pages, all demographic info and signatures MUST be repeated.</p> <p>Multiple prescriptions can be printed on a single form.</p> <p>The EMR Offering MUST identify each user and the timestamp for each time the prescription is printed/re-printed. Accessing the audit log for this information is not an acceptable solution.</p>	M	P
EMR04.06	Performs drug-to-drug interaction checking: <ul style="list-style-type: none"> - indicating severity; - allowing override; and - using a drug interaction database with Canadian drug codes 	<p>This decision support tool MUST be a publicly available, commercial off-the-shelf (COTS) drug database.</p> <p>A drug interaction database that is current MUST be used.</p>	M	P
EMR04.07	Performs drug-to-allergy and drug-to-intolerance interaction checking: <ul style="list-style-type: none"> - indicating patient allergy severity; - allowing override; and - using an interaction database with Canadian drug codes 	<p>This decision support tool MUST be a publicly available, commercial off-the-shelf (COTS) drug database.</p> <p>A drug interaction database that is current MUST be used.</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR04.08	Performs expanded drug interaction review	<p>This decision support tool MUST be a publicly available, commercial off-the-shelf (COTS) drug database.</p> <p>A drug interaction database that is current MUST be used.</p> <p>One or more of:</p> <ul style="list-style-type: none"> - drug/condition interactions, - drug/lab interactions, - recommended dosing, - therapeutic alternatives 	O	P
EMR04.09	Provides options to manage medication alerting for drug-drug interactions at the physician level	<p>The EMR Offering MUST have the ability to set the threshold for the display of medication alerts at the EMR user (physician) level.</p> <p>Settings made at the physician level MUST supersede settings made at the organization level.</p> <p>Additional example workflows may include:</p> <ul style="list-style-type: none"> - After the first time, a warning is presented to an EMR user, the EMR user should be provided with the option to default to “managed” that particular warning in subsequent viewings. - If a previously managed alert does not display, in the situation where medication information in the interaction database or the condition of the patient is updated, alerts previously defaulted to “managed” will retrigger. 	M	P
EMR04.10	EMR Offering provides options to manage medication alerting for drug-drug interactions at the organization level.	<p>The EMR Offering MUST have the ability to set the threshold for the display of medication alerts at the organization level.</p> <p>Additional example workflows may include:</p> <ul style="list-style-type: none"> - If a previously managed alert does not display, in the situation where medication information in the interaction database or the condition of the patient is updated, alerts previously defaulted to “managed” will retrigger. 	O	P
EMR04.11	EMR Offering provides options to manage medication alerting for drug-drug interactions at the per patient/per physician level.	<p>The EMR Offering MUST have the ability to set the display of medication alerts at the per patient/per physician level.</p> <p>Settings made at the per patient/per physician-level MUST supersede settings made at the physician or organization level.</p> <p>Additional example workflows may include:</p>	O	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<p>- If a previously managed alert does not display, in the situation where medication information in the interaction database or the condition of the patient is updated, alerts previously defaulted to “managed” will retrigger.</p>		
EMR04.12	<p>Provides a view of the current medication treatment plan, allowing the ability to change the view of medications between Current, Past, and All</p>	<p>Purpose of this requirement is to assist physicians in organizing the view of medication information for a particular patient.</p> <p>To maintain an accurate view of a patient’s medication treatment plan, the ability to display current medications, rather than a chronological list of medication prescribing activities is essential.</p> <p>Current medications and historical medications do not have to be separate screens, as long as the current medications are grouped, displayed and identified as current.</p> <p>Provide views for current and past treatment plans showing drug name, and prescription date at a minimum.</p> <p>The CPSO Medical Records Policy requires the ability to display at a minimum a list of the chronic medications in the patient’s treatment plan.</p>	M	P
EMR04.13	<p>Presents a patient’s medication dosage information over time for an EMR user-selected medication</p>	<p>At a minimum, medication name, dosage, and start date MUST be displayed.</p> <p>EMR user MUST be able to select any medication in the patient’s medication list.</p> <p>Information MUST be printable. Printed information MUST include all data elements referenced in the requirement.</p>	M	P
EMR04.14	<p>Provides the ability for an EMR user to view the date of the last update to the drug database</p>	<p>At a minimum, date of last update information MUST be viewable from within the medication module of the EMR Offering (e.g., from a menu item accessible from the medications module).</p> <p>It is strongly recommended this date is included within a centralized source of dates and licensing information.</p> <p>EMR user is not required to have administrative permissions to view the date of the last update.</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR04.15	Provides updates to the EMR drug database at a minimum frequency of every two months	It is acceptable for vendors to notify and provide access to updates for customers to update their on-site EMR Offerings.	M	P
EMR04.16	Provides the ability to capture a refill quantity and refill duration (days' supply) which differs from the first dispensing	Refer to the EMR Core Data Set Specification for medication data elements.	M	P

Lab Test Management

For the purposes of this section, the following terms are defined:

- Test Report means a response from one laboratory at one date/time concerning one patient. A Lab Test Report may contain several Lab Test Results.
- Test Result means a single result of a single laboratory test.

For Commercial Laboratory interface requirements, refer to section 0 Interface Requirements

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR05.01	Provides the ability to maintain laboratory test results as separate data fields	Refer to the EMR Core Data Set Specification for laboratory test data elements.	M	P
EMR05.02	EMR Offering MUST provide a visually distinct method of indicating new laboratory Test Reports through the physician work queue and the patient chart	New test reports are considered to be those that the physician has received and has not yet opened and/or viewed. At a minimum, the functionality MUST be available to: - the ordering physician - copied to physician(s)	M	P
EMR05.03	EMR Offering MUST provide a visually distinct indication of abnormal laboratory Test Reports through a physician work queue and the patient chart	At a minimum: - Test Reports MUST display an 'abnormal' flag without opening the actual result - Test Reports need to be "sortable" such that after being sorted, abnormal lab reports appear at the top of the list	M	P
EMR05.04	EMR Offering MUST provide a visually distinct indication of which laboratory Test Result(s) within a Test Report is abnormal.		M	P
EMR05.05	Graphically presents laboratory Test Results and reference ranges over time for EMR user-selected test name	Graph MUST show: - Test Name, - Test Result Value - Reference Ranges, and - Collection Date (if available) Scales MUST be appropriate to the data. Graph MUST be printable. The printed graph MUST include all data elements referenced in the requirement.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR05.06	Displays, as data points, EMR user-selected patient medications or other interventions directly on the graph identified in requirement #EMR05.05	The use of mouse hovering or tool tips does not meet the requirement. Printed graph MUST include all data elements referenced in the requirement.	O	P
EMR05.07	In a table format, presents laboratory Test Results over time for an EMR user-selected Test Name	Table MUST show: - Test Name(s), - Test Results Values - Collection Date (if available) The table MUST be printable. The printed table MUST include all data elements referenced in the requirement.	M	U
EMR05.08	Prints lab summaries and explanations for patients in lay terms, or in language that is easy for the patient to understand	A lab summary is a printed summary of Test Results in tabular or graphical format, grouped by Test Name. An explanation can be provided via the physician appending notes through the EMR Offering, or via templates that are specific to the Test Names on the lab summary.	O	P
EMR05.09	Supports scanning of laboratory Test Reports into the EMR Offering with the ability to indicate the Lab Reports with abnormal results	EMR Offering MUST provide a visually distinct indication of abnormal scanned laboratory reports through a physician work queue and the patient chart.	M	P
EMR05.10	Supports adding annotations that are tied to each laboratory Test Report and Test Result by the physician	These are free form text notes added by the physician at the overall Test Report level and Test Result level (refer to Core Data Set Data Element "DE10.017 - Physician Notes").	M	P
EMR05.11	Capable of reconciling laboratory Test Results with orders so that outstanding laboratory tests can be identified	EMR user MUST be able to simultaneously view and compare the ordered and received lists of laboratory tests. Reconciliation may be automatic, manual, or a combination of both. Some lab orders may exist without matched results (i.e., the patient did not go to a lab). The EMR Offering MUST provide the ability to remove an order from the reconciliation list if desired.	M	P
EMR05.12	Laboratory Test Reports/Results can be associated with a specific patient record.	Relates to any laboratory tests results received by the EMR Offering: - through an interface, - scanned into the EMR Offering, or - manually entered	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR05.13	Incorporates functionality that allows EMR users to cross-reference the EMR Offering's proprietary Test Names to the Test Codes/Test Names from different laboratory proprietary standards	Mapping of test codes to test names in the EMR Offering may be provided by the EMR vendor, or the EMR Offering MUST provide the ability for an EMR user to perform this mapping manually.	M	P
EMR05.14	Incorporates functionality that allows EMR users to cross-reference the EMR Offering's proprietary Test Names to the LOINC Codes as specified in the OLIS Nomenclature Standard	Refer to the OLIS Nomenclature standard documentation here: https://www.ehealthontario.ca/portal/server.pt/community/olis_reference_information_and_adoption_toolkit/2504 Access to the nomenclature files requires a free ONE® ID account issued by eHealth Ontario.	M	U
EMR05.15	Provide the ability to complete the Ontario Lab Requisition Form electronically, prior to printing	The EMR Offering MUST support checking of appropriate boxes, as well as adding text entry within the appropriate sections of the standard form. Creation of the lab requisition from within the EMR Offering does not require a preview of the completed form, but the requested tests and the date/time of the lab requisition order MUST be maintained in the EMR Offering within the patient record. The physician signature is still required on the completed (printed) form. Standard laboratory requisition form may be updated at MOHLTC discretion and EMR Offerings are required to conform to the most recent update. <i>Current form available at:</i> http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ACT=RDR&TAB=PROFILE&ENV=WWE&NO=014-4422-84 .	M	U
EMR05.16	Automatically populates and prints the demographic information for patient and physician in the appropriate fields on the Ontario Lab Requisition Form	Standard laboratory requisition form may be updated at MOHLTC discretion and EMR Offerings are required to conform to the most recent update. <i>Current form available at:</i> http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ACT=RDR&TAB=PROFILE&ENV=WWE&NO=014-4422-84 .	M	P
EMR05.17	Allow laboratory Test Report(s) / Result(s) to be received and associated with a patient record without requiring the creation of a laboratory requisition	The lab result needs to be received and associated with a patient record without the manual or automated creation of a lab requisition.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR05.18	The EMR Offering MUST be able to manage partial laboratory Test Reports in a manner that does not clutter the medical record.	<p>The default view is the most recent report received in the patient chart.</p> <p>The EMR user MUST be able to identify the annotations related to any Test Reports and Test Results, both partials and final.</p>	M	P

External Document Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR06.01	Able to import external documents to become part of the EMR Offering	<p>Refer to the EMR Core Data Set Specification for report data elements.</p> <p>Relates to any external document received by the EMR Offering:</p> <ul style="list-style-type: none"> - through an interface, - scanned into the EMR Offering <p>Copying and pasting the text from the original document into the EMR would not meet the requirement.</p>	M	P
EMR06.02	External documents imported or scanned into the EMR Offering can be associated with a specific patient record.	Patient documents stored within the EMR Offering MUST be viewable within the patient record, even if not yet viewed or signed-off by the responsible physician.	M	P

Cumulative Patient Profile (“CPP”) Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR07.01	Displays Cumulative Patient Profile (CPP), clearly identifying the summary patient information	<p>At a minimum, the CPP displays the following categories:</p> <ul style="list-style-type: none"> - Ongoing Health Conditions - Past Medical & Surgical History - Family Medical History - Immunization Summary - Allergies & Adverse Reactions - Medication Summary - Risk Factors - Medical Alerts & Special Needs <p><i>Refer to requirements EMR07.02 - EMR07.08 regarding CPP categories.</i></p> <p><i>Refer to the CPSO policy on Medical Records for information about the CPP.</i></p>	M	P
EMR07.02	Displays Ongoing Health Conditions	Referenced also as ongoing (current) Health Condition or Diagnosis List.	M	P
EMR07.03	Displays Past Medical and Surgical History		M	P
EMR07.04	Displays Family Medical History		M	P
EMR07.05	Displays Allergies and Adverse Reactions		M	P
EMR07.06	Displays Medications summary	Can display ongoing medication treatment plan as the default. Can also include current acute medications.	M	P
EMR07.07	Displays Risk Factors		M	P
EMR07.08	Displays Medical Alerts and Special Needs		M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR07.09	Provides a method of re-ordering/sorting the CPP items at the EMR user's discretion	<p>The user MUST be able to order the list in any way they choose for each CPP category for a patient:</p> <ul style="list-style-type: none"> - Ongoing Health Conditions - Past Medical and Surgical History - Family History - Allergies and Adverse Reactions - Medication Summary - Risk Factors - Medical Alerts and Special Needs <p>Allowing the EMR user to only sort the items alphabetically will not satisfy the requirement.</p> <p>Re-ordered items should be maintained on the patient CPP in subsequent logins.</p>	O	P
EMR07.10	Provides the ability to manage and update the CPP summary from the encounter data	At a minimum, Medications and Ongoing Health Conditions (problems, diagnoses) can be selected and managed from the encounter note to update the CPP.	M	P
EMR07.11	MUST be able to customize the view to manage one or more sections of the CPP	<p>At a minimum, the EMR user MUST be able to:</p> <ul style="list-style-type: none"> - add and remove CPP categories for display - add and remove discrete data information to display within the CPP categories <p>Customizations can be made at the EMR user level.</p> <p>Customizations made MUST be maintained in subsequent logins by the EMR user.</p>	M	P
EMR07.12	SHOULD be able to support additional customizations of the CPP	<p>Accepted solutions include (but are not limited to):</p> <ul style="list-style-type: none"> - resizing CPP categories to optimize data display and scrolling <p>Any customizations MUST be maintained in subsequent logins by the EMR user.</p>	O	P
EMR07.13	CPP can be printed to a single document as a single operation	<p>Sections of the CPP MUST be clearly identifiable within the printed document.</p> <p>Printed document MAY exceed one page.</p>	M	P

Encounter Documentation Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR08.01	Provides forms or templates for common encounters that can be modified by an EMR user	Examples: SOAP, Annual Physical, Ante-natal, etc.	O	P
EMR08.02	Automatically includes an EMR user identifier in each part of the encounter note to support shared creation of encounter documentation	The following would NOT meet the requirement: - manual entry of identification (e.g., initials) - comparing encounter note versions to identify what information was entered by an EMR user - requiring the EMR user to access audit logs to view entry information Allowing EMR users to toggle identifying information within the encounter note view is acceptable if the identifier information can be retrieved.	M	P
EMR08.03	Supports free form text notes that are tied to each encounter		M	P
EMR08.04	Provides the ability to view and print all encounter documentation in chronological order	<i>Based on Ontario Regulation 114/94, Section 20 (4).</i>	M	P
EMR08.05	Provides the ability to view and print all encounter documentation in chronological order by date range as selected by the EMR user	At a minimum, the EMR user should be able to select both a start date (day, month, year) and an end date for the date range to satisfy this requirement.	M	P
EMR08.06	Provides the ability to discretely capture more than one diagnosis for a single encounter	Whether the EMR Offering supports free text, coding or other data discipline of entering and capturing multiple diagnoses within an encounter note, each method should discretely capture diagnoses at the physician's discretion.	M	P
EMR08.07	Provides the ability to compile the components of a multi-part visit to create an encounter note that represents a single office visit per patient	Allow for a logical grouping of encounter documentation that clearly indicates multiple activities within a single office visit.	M	P

Schedule Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR09.01	Maintains appointment data	Refer to the EMR Core Data Set Specification for appointment data elements.	M	P
EMR09.02	Provides the ability to flag appointments as critical (visually distinct)		M	P
EMR09.03	Integrates with billing component to avoid duplicate patient data entry. MUST transfer at least two of the elements required to complete billing	At a minimum, the two elements that can be transferred from the scheduling MUST be: - the patient's health card number and - service date	M	P
EMR09.04	Able to open a patient medical record directly from a scheduled appointment without having to perform another search for the patient		M	P
EMR09.05	Supports view of a multi-doctor schedule	MUST display two or more physicians per screen. Appointment dates and times are synchronized on the screen when scrolling.	M	P
EMR09.06	Supports searching for next available appointment by all of the following in a single function: - physician, - day of the week, - time of day, and - appointment type	MUST be an online function, not a report.	M	P
EMR09.07	The schedule is printable as day-sheet sorted alphabetically by patient name		M	P
EMR09.08	The schedule is printable as day-sheet sorted chronologically	Day-sheet should be in ascending order (i.e., earliest time should appear at the top of the sheet).	M	P
EMR09.09	The schedule is printable as day-sheet sorted by chart number		O	P
EMR09.10	Supports pre-configuration of schedule slots or blocks by the physician		O	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR09.11	Supports planned periods of multiple appointments to a single start time	Ad hoc double booking does not meet the requirement. MUST be: - visually distinct; - preplanned and configured; and - able to search for next available slot or overbooking occurs only after the planned period is full	O	P
EMR09.12	Supports ad hoc double booking that is: - visually distinct, and - shows on the printed schedule	Ability to book an appointment that overlaps with another appointment(s), without needing to configure the schedule.	M	P
EMR09.13	Supports schedule viewing both with and without personal patient data showing.	Showing only the patient name on-screen without patient data is acceptable. Displaying patient data when hovering over appointments is not acceptable. The EMR user MUST be able to toggle between displaying and hiding patient data viewable in the schedule.	M	P
EMR09.14	Supports drag and drop rescheduling.	Can be cut and paste or any other means of rescheduling without a delete and add process.	O	P
EMR09.15	Supports the display of the status of the patient in the clinic.	EMR Offering may have pre-defined status definitions or allow for EMR user-defined status.	M	P
EMR09.16	Provides the ability for a physician to view and modify their schedule.		M	P
EMR09.17	Provides a view for appointment history for any given patient in the EMR.	The view includes both past and future appointments.	M	P

Referral Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR10.01	EMR Offering supports referral letter templates, specific to specialty.	<p>The letter templates MUST:</p> <ul style="list-style-type: none"> - integrate patient demographics (i.e., name, age, DOB, gender, Ontario health card number, patient contact information) from the EMR Offering - include physician's letterhead and contact information - referring physician's name and contact information - integrate clinical data from the patient record as selected by the physician including: <ul style="list-style-type: none"> - CPP data - Lab Test Reports / Test Results, - Progress notes (encounter notes), - Consultation notes (received), - External reports (e.g., diagnostic images), - be able to be edited to provide letter-specific content <p>Letters generated from the template MUST be:</p> <ul style="list-style-type: none"> - saved in their original form - the date saved is the date the letter was generated - updates made to the patient medical data after letter generation MUST not affect and update the saved letter 	M	P
EMR10.02	EMR Offering tracks referrals and provides a reminder if outstanding.	<p>Reminders MUST:</p> <ul style="list-style-type: none"> - be visually distinct, - be in the patient record, - identify referral physician, and - be turned off at EMR user discretion 	M	P

Reporting, Query and Communications

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR11.01	All EMR data MUST be able to be produced in a hard copy format.	<p>In order for this requirement to be met, this MUST be EMR user-administered and does not require an EMR vendor to attend the process.</p> <p>MUST be able to print information for a single patient record.</p> <p>See CPSO Medical Records Policy: http://www.cpso.on.ca/policies-publications/policy/medical-records.</p>	M	P
EMR11.02	<p>Allows EMR users to set up preventive care parameters required for Patient Recall List and Cumulative Bonus Report generation for each of the five (5) preventive care categories:</p> <ul style="list-style-type: none"> - mammogram - pap smear - colorectal - immunization - influenza 	<p>EMR user MUST be able to set up and maintain the following parameters for the target populations:</p> <ul style="list-style-type: none"> - enrolment status - age - gender - procedure/vaccination timeline - exclusion codes <p>The parameters applicable MUST be adjustable and saved:</p> <ul style="list-style-type: none"> - on a fiscal year basis for Cumulative Bonus Reports - on a real-time basis for Patient Recall List <p>Hard-coding the parameters would not satisfy this requirement.</p> <p>Service Enhancement Codes are set by the MOHLTC for applicable Physician Group Agreements. See the <i>OHIP Bulletins and MOHLTC guidelines</i>.</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR11.03	Generates Patient Recall List report for preventive care activities/programs for patients enrolled to a physician.	<p>Patient Recall List MUST include/indicate:</p> <ul style="list-style-type: none"> - target population - the physician to whom the patient is enrolled - patient information (name, Ontario health card number, age, gender, phone number, address) - guardian information (name, phone number and address) for Childhood Immunizations - whether the patient is entitled to receive the first letter, second letter or phone call - last procedure date - last date of communication (printed letters or phone call) <p>The Patient Recall List is a real-time report. Updates to patient data, report parameters and letter generation MUST be automatically reflected in the Patient Recall List report.</p> <p>Requiring EMR users to re-enter any information (e.g., Demographic and EMR information) already in the EMR Offering would not satisfy the requirement.</p> <p>Service Enhancement Codes are set by the MOHLTC for applicable Physician Group Agreements. <i>See the OHIP Bulletins and MOHLTC guidelines.</i></p>	M	P
EMR11.04	Creates patient letters directly from the Patient Recall List report.	<p>At a minimum, the EMR Offering MUST be able to:</p> <ul style="list-style-type: none"> - generate the letters in a batch and individually (both MUST be supported) - generate the letters without requiring the EMR user to do another patient lookup - save records of all correspondence including dates of delivery of the written notices <p>Letters MUST meet requirements listed in the MOHLTC Service Enhancement Codes Primary Care Agreements:</p> <ul style="list-style-type: none"> - indicate whether it is the first or second written notice - indicate the procedure type, benefits and the date of the last procedure - the name and address of the patient or guardian (for Childhood Immunizations) - physician letterhead and information (name, address, phone number) 	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR11.05	Generates Cumulative Bonus reports for preventive care activities/programs for patients enrolled to a physician.	<p>Cumulative Bonus report MUST include/indicate:</p> <ul style="list-style-type: none"> - the target population - the physician to whom the patient is enrolled - patient information (name, Ontario Health Card Number, age, gender) - last procedure date - whether the eligible patients for the selected fiscal year have received the procedure or not - percentage of patients who have received the procedure from the target population <p>The Cumulative Bonus Report is a real-time report. Updates to patient data, report parameters and letter generation MUST be automatically reflected in the Cumulative Bonus report.</p> <p>Reports can be generated for each fiscal year.</p> <p>Requiring the user to re-enter any information (e.g., Demographic and EMR information) already in the EMR Offering would not satisfy the requirement.</p> <p>Service Enhancement Codes are set by the MOHLTC for applicable Physician Group Agreements. <i>See the OHIP Bulletins and MOHLTC guidelines.</i></p>	M	P
EMR11.06	Provides a report writer which allows the EMR user to develop Ad hoc queries and run reports.	<p>The EMR user MUST be able to create the query and run the report and does not require an EMR vendor to attend the process.</p> <p>Any discrete data field specification requirements satisfied by the EMR Offering can be selected for report parameters.</p> <p>At a minimum, ad hoc reporting functionality should allow for the selection of reported fields and allow for filtering based on “AND”, “OR”, and “NOT” logic.</p> <p>Ad hoc query facility supports Boolean search capabilities.</p> <p>The tool MUST be EMR user-friendly.</p>	M	P
EMR11.07	Assists physicians with consistent data entry to facilitate effective data discipline, coding and extraction.	<p>A spell checker is not sufficient.</p> <p>Comments: Examples:</p> <ul style="list-style-type: none"> - coding schemas, - drop-down lists, etc. 	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR11.08	Able to search and report on ALL text fields in the EMR Offering	Text fields include any free-form text or notes fields. Able to search within text fields for partial matches.	M	P
EMR11.09	Able to search and report on ALL data fields in the EMR Offering.	Image data is not required.	M	P
EMR11.10	Able to search and report on ALL data and text fields in the EMR Offering concurrently (i.e., in a single report).	Able to search within text fields for partial matches. Image data is not required.	M	P
EMR11.11	Provides report templates for EMR data that may be modified by the EMR user.		O	P
EMR11.12	Allows for the identification of static cohorts of patients for the purpose of chronic disease, or other tracking.	To satisfy this requirement the physician MUST be able to define the name and population of their own cohort(s). The physician MUST be able to add a population of patients individually or in bulk to the cohort. Each patient in the EMR Offering can belong to more than one cohort if desired by the physician.	M	P
EMR11.13	EMR Usage Metrics Report	Report indicates: <ul style="list-style-type: none"> ▪ physician for whom the report is being generated ▪ date range of report ▪ practice profile information ▪ metrics for the patients rostered to physician <ul style="list-style-type: none"> - scheduled appointments - billing (OHIP, WSIB, private, uninsured) - encounter notes created - problems entered in Ongoing Health Condition list - stored documents (including scanned documents or external documents received from an interface) - new and renewed prescriptions - lab test results received electronically - alerts/reminders generated <p><i>Refer to section 0 - EMR Usage Metrics Report (Req # EMR 11.13) - Sample.</i></p>	M	P

Workflow Management

To meet the requirements of this section, an EMR Offering MUST have one or more work queues. A work queue (also known as an in-basket, in-box or task list) supports the management of tasks.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR12.01	Work queue items can be linked to a patient record.	EMR Offering MUST provide the ability to open the patient record in a single action.	M	P
EMR12.02	Supports classification of task priority.	Priority can be indicated by urgent, low, etc., or a priority checkbox.	M	P
EMR12.03	Supports free form text notes that are tied to each task.		M	P
EMR12.04	Provides the ability to associate a task with a laboratory Test Report/Result.	Laboratory Test Report/Result can be opened from the task. Assigned EMR user's access to lab information MUST follow appropriate security permissions for that EMR user.	O	P
EMR12.05	Provides the ability to associate a task with an external document.	Document record can be opened from the task. Assigned EMR user's access to document MUST follow appropriate security permissions for that EMR user.	O	P
EMR12.06	Supports the creation of new ad hoc tasks and their assignment to other specified EMR users.		M	P
EMR12.07	Supports the creation of new ad hoc tasks and their assignment to others by role.		M	P
EMR12.08	Tasks can be created, accessed, and actionable anywhere in the application.		M	P
EMR12.09	Can store selected work queue tasks and status as part of a patient's medical record.	Storing this information only in the audit log is not acceptable.	M	P
EMR12.10	Work queue screens can be customized for different roles.	Work queues can be customized by roles such as nursing, physicians, receptionists etc.	O	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR12.11	Supports automated generation of tasks and patient follow-up tasks to a work queue.	<p>At a minimum, the following tasks MUST be automatically generated:</p> <ul style="list-style-type: none"> -outstanding lab requests, and other tests (e.g., Diagnostic Imaging) - appointment reminders <p>This requirement does not include preventive care (e.g., preventive care reminders).</p> <p>The requirement is not met if an EMR user only accesses the patient chart in order to see the task.</p> <p>The EMR Offering allows the ability to turn off this functionality for each type of task.</p>	M	P
EMR12.12	Automatically creates a task for past-due targeted health maintenance activities and assigns it to a pre-defined work queue; the tasks MUST be generated by the EMR Offering, not created by an EMR user.	<p>Running a query to generate tasks on all applicable records is acceptable.</p> <p>EMR user should be able to assign/redirect tasks to a particular EMR user or role.</p> <p>EMR user should be able to turn off this functionality.</p> <p><i>See the OHIP Bulletins and MOHLTC guidelines.</i></p>	M	P
EMR12.13	Unsigned patient information MUST be visible in the patient chart and identified as such.	<p>This applies to all patient information (i.e., reports) that require sign-off such as:</p> <ul style="list-style-type: none"> - Reports received through an interface - Reports scanned into the EMR Offering - Reports manually keyed <p>A mandatory concurrent entry MUST be present in the physicians “inbox” for sign-off.</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR12.14	Supports a “sign off” function to indicate data that becomes part of the permanent patient medical record.	<p>At a minimum, sign-off should be available for:</p> <ul style="list-style-type: none"> - encounter documentation - reports <ul style="list-style-type: none"> > received through an interface > scanned into the EMR Offering > manually keyed into the EMR Offering <p>Sign-off information (including sign-off date and identity of the physician) MUST be:</p> <ul style="list-style-type: none"> - visible in the patient's chart - captured in the audit log 	M	P
EMR12.15	Supports a “sign-off” function for approval of trainee actions.	The trainee is not necessarily a physician – may be a nursing student, etc.	M	P
EMR12.16	Supports multiple physician “sign-offs” on patient information and indicates the sign-off date and physician identity.	<p>This applies to any patient information that requires physician sign-off such as:</p> <ul style="list-style-type: none"> - encounter documentation - reports <ul style="list-style-type: none"> > received through an interface > scanned into the EMR Offering > manually keyed into the EMR Offering <p>Sign-off information (including sign-off date and identity of the physician) MUST be:</p> <ul style="list-style-type: none"> - visible in the patient's chart - captured in the audit log <p>Only 1 copy of the report is posted to the patient’s chart.</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR12.17	Provides functionality from the “inbox” to allow the EMR user to re-display an item which has been signed-off	<p>This applies to all patient information signed off, such as:</p> <ul style="list-style-type: none"> - reports received through an interface - reports scanned into the EMR Offering - reports manually keyed <p>In addition, provides the ability to search and review items that were signed-off on a particular date or date range per EMR user.</p> <p>This is not an undo function, but rather the ability to display (return to) previously viewed patient information without requiring the EMR user to recall patient demographic details.</p>	M	P

Billing Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR13.01	Processes concurrent Ontario billings models of fee-for-service, shadow partial payment billings, and Physician Group bonus codes.	See the OHIP Bulletins and MOHLTC guidelines.	M	P
EMR13.02	Provides basic error checking. MUST alert EMR user when an error is detected.	At a minimum, the basic error checking to be provided when: Registering patients: - Ontario health card number - check digit, - health card number duplicate Edits for all mandatory billing fields: - service date - physician number - health card number - name - date of Birth (DOB) - gender - fee code and fee claimed - checks all dates are valid dates and in the past	M	P
EMR13.03	Provides automated reconciliation and claim re-submission and prints reconciliation reports.	The reconciliation reports can be either the entire MRO data file or include the MOHLTC defined data fields, based on their MRO record type. Supports resubmission of rejected claims without the need to re-enter data. <i>See the OHIP Bulletins and MOHLTC guidelines.</i>	M	P
EMR13.04	Supports reading a health card through a card reader device, and looking up the patient in EMR application database.	The EMR Offering MUST: - notify of version code discrepancies, and - upon EMR user request, automatically update the patient record with demographic data associated with the Ontario health card number: - name - gender - DOB	M	P
EMR13.05	Supports WSIB billing through MRI files.		M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR13.06	Can create a claim directly from patient encounter information.	MUST transfer all pertinent billing data that is present in the clinical record. Pertinent data includes, but is not limited to: - patient information - physician information - service date - procedure code - diagnosis code - location - clinic/hospital number	O	P
EMR13.07	Can transfer and translate diagnostic codes for billing purposes from the EMR component.	Diagnosis code information comes from the patient's EMR data and is not manually entered by the EMR user.	O	P
EMR13.08	Supports manual entry of non-OHIP billing transactions including: - Direct to patient - Reciprocal - 3rd Party		M	U
EMR13.09	Provides aged receivables listing for all billing types (not just OHIP).	The list MUST indicate: - patient ID - service provided - service date - outstanding amount Any ageing buckets are acceptable. Can be any report to manage outstanding claims.	M	U
EMR13.10	Contains the current OHIP fee schedule including preventive care codes.		M	P
EMR13.11	Maintains and uses historical OHIP fee schedule for the prior year.	Prior fee schedule information may be required for resubmission purposes.	M	P
EMR13.12	Provides lookup of services and diagnoses by their codes as well as their descriptions.		M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR13.13	Forces reconcilable disposition of all scheduled appointments (i.e., provides a screen or report that lists patient appointments which have no billings).	EMR user MUST take some action to remove unbilled appointments from the list. Deleting appointments does not meet the requirement.	M	P
EMR13.14	Supports direct third-party billings with invoices.	Able to be generated on demand. At a minimum, the third-party billings with invoices MUST include: - physician name - patient name or ID - payor address - service date - service - itemized amount(s) - total amount billed	M	U
EMR13.15	Supports direct third-party billings with statements.	Able to be generated on demand At a minimum, the third-party billings with statements MUST include: - physician name - patient name or ID - payor address - service date - service - itemized amount(s) amount paid - balance Receipts are not sufficient.	M	U
EMR13.16	Supports billing lookup by each of the following: - patient health card number - patient name - OHIP claim # or Accounting #	OHIP claim # is assigned by the OHIP claims payment system. Accounting # is assigned by EMR Offering or EMR user to a claim.	M	P
EMR13.17	Enables updating of billing codes through OHIP fee schedule master update file as provided by MOHLTC in the specified format.	<i>Refer to:</i> http://www.health.gov.on.ca/english/providers/program/ohip/sob/schedule_master.html	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR13.18	Notifies EMR users of changes to billing codes per the updates in the fee schedule master.	At a minimum, notifications MUST be provided for: - updated Fees - updated Effective Date - updated Expiration Date - new billing codes	O	P
EMR13.19	Provides access to OMA suggested fees for uninsured services and third-party services, including HST eligibility.	OMA Suggested Fees for uninsured services and third-party services can be accessed from scheduling and billing modules, and the patient's medical record. For a list of suggested fees for uninsured services and third-party services, refer to the document <i>"Physician's Guide to Third-Party & Other Uninsured Services"</i> published by the Ontario Medical Association.	M	P
EMR13.20	Provides the capability of correcting a billing entry error without classifying it as a write-off.	A 'write-off' implies an uncollectable amount. These amounts should be coded and treated as such. An 'error' is an honest error and should be treated as such. Write-offs and errors should be associated with a reason code/reason description. Report(s) that show write-offs and error corrections should clearly show each.	M	P

System Access Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR14.01	EMR users MUST enter a password in order to access EMR Offering functions. EMR MUST store passwords in an encrypted format.	Encryption applies to password managed by EMR Offering. Passwords stored and managed by the operating system are already considered encrypted and secure.	M	P
EMR14.02	EMR Offering MUST support passwords that include: - mixed case passwords; - passwords of a minimum of 8 characters; - alphanumeric characters; and - special characters		M	P
EMR14.03	EMR Offering MUST have password management capabilities that can be deployed based on EMR user discretion.	Password management capabilities include: - the ability to set parameters for the number of failed login attempts within a certain time period; and - the ability to set time parameters for password expiry This applies to all passwords used by the EMR Offering, including the operating system and all applications.	M	P
EMR14.04	EMR Offering MUST be able to share patient data among physicians who access the same database.	MUST maintain proper physician identification. Patient data MUST only be shared if permitted by practice rules.	M	P
EMR14.05	Provides the capability to create roles.	Need to be able to create new roles, with customized permissions. If the EMR Offering provides only pre-defined roles, this requirement is not met. Changes applied to a role means that this change is applied to all members of that role. Multiple roles can be assigned to EMR users.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR14.06	There are access controls to functions based on roles.	Members of a role have access/restrictions to certain screens and capabilities in the EMR Offering based on the functions assigned to that particular role. For example, the EMR Offering should ensure the merge function can be assigned to a specific user(s), EMR user role or group.	M	P
EMR14.07	There are access controls to data based on roles.	Members of a role cannot access certain data, even though that role can access a function that uses the data. It gives control over what the role can access at the physical or logical record level.	M	P
EMR14.08	There are access controls to functions based on EMR user.	An EMR user cannot use certain screens or capabilities of the EMR Offering.	M	P
EMR14.09	There are access controls to data based on the EMR user.	An EMR user cannot access certain data, even though that EMR user can access a function that uses the data. It gives control over what the EMR user can access at the physical or logical record level.	M	P
EMR14.10	Provides different views to data for roles.	Screen layout, organization, or contents can be customized for different roles.	O	P
EMR14.11	Clerical staff who do not have permission to view patient medical data can enter notes into the EMR Offering.	Notes entered against practice management data (e.g., patient demographics, appointments) would not meet the requirement.	M	U
EMR14.12	EMR Offering MUST ensure the encryption of: - passwords transmitted over a WAN. - data transported across private or public networks. - data stored off-line (back-ups, archives, etc.)		M	P
EMR14.13	Provides the ability for multiple EMR users to access the EMR Offering concurrently.	Single EMR user access to EMR Offerings is not accepted.	M	P
EMR14.14	Provides the ability for concurrent EMR users to simultaneously view the same record.	Refers to practice management information, as well as clinical information.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR14.15	Provides protection to maintain the integrity of clinical data during concurrent access.	To prevent EMR users from simultaneously attempting to update a record with resultant loss of data.	M	P
EMR14.16	Provides a way to quickly “lock” an EMR user workstation if left unattended.	<p>Following rules MUST apply:</p> <ul style="list-style-type: none"> -EMR user MUST be required to enter a valid password in order to unlock workstation - MUST preserve context when unlocked - MUST be quick; a screen saver after 30 minutes is not acceptable - EMR data MUST not be accessible <p>Acceptable solutions are:</p> <ul style="list-style-type: none"> - EMR user-initiated lock (e.g., hotkey); and - screen lock with a timeout period 	M	P
EMR14.17	Ensures security when one EMR user is logged on at multiple workstations.	MUST be able to log on to the EMR Offering through a second workstation with the same EMR user credentials without logging out of the first workstation.	M	P
EMR14.18	Ensures security when several EMR users use the same workstation in quick succession to access: a) a single patient record or b) multiple patient records.	<p>MUST be able to log on to the EMR Offering with a second set of EMR user credentials without logging out the first EMR user.</p> <p>Second EMR user cannot see the first EMR user’s data and vice versa.</p> <p>If an EMR Offering uses operating system features (e.g., user profile switching) to meet this requirement, then a version of the OS that provides this feature MUST be included as part of the EMR.</p>	M	U
EMR14.19	Supports Remote Access through internet connections using Virtual Private Network (VPN)	<p>MUST be able to use all EMR functions when connected remotely.</p> <p>A VPN MUST be supported to offer remote connections (e.g., access from home).</p>	M	P

Data Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR15.01	MUST retain medical records information.	It is recommended to maintain records for a minimum of 15 years. See CPSO Medical Records Policy: http://www.cpso.on.ca/policies-publications/policy/medical-records	M	P
EMR15.02	MUST retain billing transaction details for at least 7 years.	This standard may be updated by MOHLTC.	M	P
EMR15.03	Supports a minimum of 20,000 patient records for up to 10 years of data without the need to upgrade Database Management System (DBMS), Operating System (OS) or other software components.	Vendor MUST provide substantiation that databases with inherent limitations, such as MSDE or MS Access, can meet this requirement.	M	P
EMR15.04	Provides a complete system (applications and data) back-up and recovery process.	<i>Based on Ontario Regulation 114/94, Section 20 (7).</i> Back-up can be full or incremental, etc. Recovery can be to last back-up, point of failure, etc.	M	P
EMR15.05	External documentation MUST be stored using a database solution.	Refer to the external documentation described in section 0 External Document Management A solution that stores documents in the file system (server or client) only does not satisfy the requirement.	O	P
EMR15.06	Encrypts patient data and clinical management data resident on server(s) with a strength of at least 128-bits.	A solution that only encrypts data as it is transmitted over the network does not satisfy the requirement.	O	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR15.07	Harden the EMR server in preparation for server-level encryption.	<p>Server hardening consists of creating a baseline for the security of the application server. Threats to Personal Health Information breaches via external access are greatly reduced by eliminating entry points and minimizing system software.</p> <p>The physical security is elevated when all application data and information are encrypted.</p> <p>This guideline does not apply to ASP versions.</p> <p><i>Refer to the Server Hardening Checklist on the OntarioMD.ca website.</i></p>	M	P
EMR15.08	An anti-malware solution and EMR Offering MUST be able to co-exist without conflicts.	Vendor MUST recommend to physicians an anti-malware solution that does not negatively impact the EMR Offering and that both solutions can co-exist on the same server without creating any conflicts.	M	P

Auditing and Logging

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR16.01	<p>There will be a complete audit trail of medical records in accordance with the CPSO requirements.</p> <p>Each patient record in the EMR Offering MUST have a distinct audit trail.</p>	<p>All activity (i.e., data viewed, updated, deleted) against medical records maintained by the EMR MUST be captured in the audit trail. The audit trail MUST capture:</p> <ul style="list-style-type: none"> - the date and time of the activity - the EMR user who accessed the data - any changes in the recorded information - preserves the original content of the recorded information when changed or updated <p>Data MUST not be altered, removed or deleted, just marked as altered, removed or deleted.</p> <p>Audit trail MUST be printable:</p> <ul style="list-style-type: none"> - separately from the recorded information for each patient - cannot contain references that are meaningless outside of the EMR Offering context <p>Refer to CPSO Medical Records Policy audit requirements: http://www.cpso.on.ca/policies-publications/policy/medical-records</p>	M	P
EMR16.02	<p>MUST have an audit trail for all add/change/delete operations on all EMR (non-medical record) data, including permission metadata.</p> <p>Data MUST not be altered, removed or deleted, just marked as altered, removed or deleted.</p>	<p>Non-medical data includes practice management data (i.e., appointments, billing) and EMR configuration data that deals specifically with customizable behaviour of the EMR Offering.</p> <p>Updated information MUST retain original data entry as well.</p>	M	P
EMR16.03	<p>MUST NOT allow for the capability to disable the audit trail. This applies to medical and non-medical records within the EMR Offering.</p>	<p>This functionality is mandatory per CPSO regulations (<i>see CPSO Medical Records Policy</i>).</p>	M	P
EMR16.04	<p>Each record in the EMR Offering will include a date/time stamp and user ID for the update of that record.</p>	<p>Can be visible either on the chart or through an audit trail.</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR16.05	Audits and logs all logins, successful and failed, at the EMR server.	<p>The log MUST include:</p> <ul style="list-style-type: none"> - timestamp - EMR user ID/application ID - originating IP address - port accessed or computer name <p>Both local and remote logins MUST be auditable.</p>	M	P
EMR16.06	Audits and logs traffic that indicates unauthorized activity encountered at the EMR server.	<p>The log MUST include:</p> <ul style="list-style-type: none"> - timestamp - user ID/application ID - originating IP address - port accessed or computer name <p>Anonymous access for services installed and running on the server (e.g., FTP, Telnet, Web) is not allowed.</p> <p>If the EMR Offering does not require any additional services, i.e., the services are disabled, this requirement is then met.</p>	M	P
EMR16.07	Audits and logs access to components of the medical record from outside the EMR Offering.	<p>Including:</p> <ul style="list-style-type: none"> - external ODBC connections used to execute SQL queries; - EMR data stored external to the database such as attachments; and - all data files used to meet other EMR local requirements (e.g., reporting requirements) <p>The log MUST include timestamp, user ID/application ID and database operation.</p>	O	P
EMR16.08	MUST synchronize the system time with a Network Time Protocol (NTP) server	System time MUST be synchronized with a trusted source to maintain audit trail integrity.	M	P

Implementation Support

This section consists of the implementation support requirements. EMR implementation support means that a representative of the vendor is available to assist customers with training and any questions about, or issues encountered with the vendor’s EMR Offering within the defined availability.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR17.01	Provides EMR Offering support from 8 AM – 8 PM Monday through Thursday, 8 AM – 5 PM Friday, and 9 AM – 2 PM Saturday (Eastern Time Zone).		M	P
EMR17.02	Provides additional EMR Offering support (e.g., 7 x 24 support).		O	P
EMR17.03	EMR vendor is able to troubleshoot common technical/user issues via electronic/remote support.	In order to satisfy this requirement, EMR vendor MUST be able to provide support by viewing EMR user interface without physically being at a site, provided appropriate consent has been given to the EMR vendor to do so. Considerations MUST be made with respect to the privacy and security of Personal Health Information.	M	P
EMR17.04	EMR vendor is able to remotely provide simple upgrades and code corrections.	In order to satisfy this requirement, EMR vendor MUST be able to: - push updates and administrator to download, accept and execute - schedule a time with the user and make updates remotely	M	P
EMR17.05	EMR user documentation is available in electronic format.	The documentation MUST be comprehensive of all available EMR functionality. To satisfy this requirement, documentation MUST either be distributed to or made available for download by customers. The document MUST be searchable.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR17.06	Provides context-sensitive help within the application.	<p>Help MUST be invoked from within the EMR user interface and specific to the screen, function or function groups being used.</p> <p>The use of tooltips to provide a brief description of a function does not satisfy this requirement.</p> <p>Opening up the entire training document and doing a search does not satisfy this requirement.</p>	O	P
EMR17.07	Offers EMR training.	At a minimum, training MUST be offered on all functionalities described in this specification.	M	P

Interface Requirements

The vendor will be required to interface their EMR Offering to other related systems.

Technical details of interfaces (such as message structure, frequency of update, push or pull) are available from interface owners.

The following table summarizes the vendor requirements for interfaces.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR18.01	Claims and Incentive Payments through the MOHLTC Billing system.	Refer to: http://www.health.gov.on.ca/en/pro/publications/ohip/	M	P
EMR18.02	Commercial Laboratories – MUST support at least one of the following: - Dynacare - LifeLabs	For this requirement to be met, the EMR vendor MUST obtain a letter certifying the successful interface. The letter MUST be dated within the previous twelve (12) months.	M	P
EMR18.05	EMR Offering MUST support validation of Ontario health cards through the Ontario Ministry of Health using at least one of the following: - OBEC (Overnight Batch Eligibility Checking). - HCV (Real-Time Health Card Validation)	Refer to the <i>MOHLTC Health Card Validation Manual</i> .	M	P

Claims and Incentive Payments

The MOHLTC Claims system processes physician claims, creates payments and provides error reports and remittance advice back to physicians. Vendors are required to implement the current interface specification and to remain current with this specification and any changes thereto.

Detailed specifications for both submitting claims and receiving error reports and remittance advice, as well as contact information for testing the interface, can be found at the following link: <http://www.health.gov.on.ca/en/pro/publications/ohip/>

Commercial Laboratories

An EMR Offering's ability to receive laboratory results from major commercial labs is subject to the following pre-conditions:

- the laboratory has made their interface specification publicly available; and
- the potential electronic transactions for the laboratory represent at least 5% of the overall Ontario volume of electronic laboratory transactions.

The specifications for electronic interfaces for two commercial laboratories meeting the above conditions can be obtained directly from the laboratories themselves.

- Dynacare – www.dynacare.ca
- LifeLabs (Formerly MDS Inc. and acquired Canadian Medical Laboratories) – www.lifelabs.com

Health Card Validation

The MOHLTC Health Card Validation (HCV) system allows health care providers to validate the eligibility of the cardholder and the status of his or her health card and version code.

The HCV Reference Manual, containing detailed specifications for current health card validation access options, as well as contact information for testing the interface, can be found at the following link:

http://www.health.gov.on.ca/english/providers/pub/ohip/ohipvalid_manual/ohipvalid_manual_mn.html

Licensing Requirements

This section consists of the requirements for the licensing of EMRs to be eligible for sale in Canada/Ontario.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR19.01	The EMR vendor MUST hold and maintain ISO 13485 certification for the EMR Offering as required by Health Canada's medical device licensing requirements.	EMR vendors MUST check Health Canada's medical device licensing requirements to determine which version of the ISO 13485 standard is required for certification.	M	U

Privacy Requirements

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR20.01	The EMR Offering MUST comply with all Applicable Laws and regulations now or hereafter in force relating to privacy and the protection of personal information, including personal health information and enable health information custodians to comply with the requirements set out therein.		M	P

Security Requirements

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
EMR21.01	The EMR vendor MUST have an application-level Privacy Impact Assessment (PIA), and Threat and Risk Assessment (TRA) completed on the EMR Offering by an Information Security Professional with the appropriate credentials (e.g., CISSP: Certified Information Systems Security Professional).	The focus of the PIA and TRA is on the EMR Offering as a Commercial off-the-shelf (COTS) software and should take into account typical deployment scenarios but does not need to be completed for every installation at a clinic.	M	N
EMR21.02	The EMR vendor MUST perform all TRAs in accordance with industry-accepted standards such as Harmonized Threat and Risk Assessment Methodology (HTRA) published by the Communications Security Establishment Canada (CSEC).		M	N

4. SUPPORTING INFORMATION

EMR Usage Metrics Report (Req # EMR 11.13) - Sample

The vendor can produce reports related to EMR use metrics (sample below).

EMR Usage Report

Provider: Dr. J. Doe

Date Range: 01/01/10 – 01/03/10

Practice Profile

Practice Size: _____

Age and Gender Distribution:

Age Group - Years	Percentage	Male	Female
0 - 19	30%	65%	45%
20 - 44	20%	20%	80%
45 - 64	30%	45%	55%
65 - 84	25%	40%	60%
85+	5 %	25%	75%

The number of unique patient visits (kept) which demonstrates the use of the following EMR functionality in the identified time frame:

Scheduled Appointments	Billing ¹	Encounter Note ²	Ongoing Health Conditions ³	Stored documents ⁴	Prescriptions new/renewals	Use of reminders / alerts ⁵	Labs ⁶
100	98	100	75	50	46	100	25

Note:

1. Bill for services – includes OHIP, WSIB, other provincial plans, private insurance and uninsured (self-pay, third parties) invoicing

2. Encounter notes (SOAP, Progress Notes, etc.) for patients seen; progress note entry associated with a kept patient office visit
3. Ongoing health conditions, problems, diagnoses from CPP.
4. Store documents not originating from by the practice; includes any scanned documents or external documents delivered through an electronic interface (e.g., through Health Report Manager).
5. Generate automated alerts/reminders to support care delivery– includes medication alerts (drug-drug, drug-allergy, drug-condition); preventive care and chronic disease management reminders
6. Received lab results electronically, directly into the EMR from private labs or hospital labs.

5. RETIRED REQUIREMENTS

This section consists of the EMR functional requirements that were retired from Core EMR Specification Section 1: EMR Baseline Requirements v4.2

Scoring:

M = Mandatory criteria

W = Weighted criteria

Status:

N = New requirement for this EMR Specification

P = Previous requirement from Core EMR Specification Section 1: EMR Baseline Requirements v4.2

U = Updated from the previous Core EMR Specification Section 1: EMR Baseline Requirements v4.2

R = Retired from previous Core EMR Specification Section 1: EMR Baseline Requirements v4.2

OMD #:

A unique identifier that identifies each requirement within OntarioMD's EMR Requirements Repository

YEAR:

The year the requirement became part of the OntarioMD EMR Requirements Repository

YEAR Retired:

The year the requirement was retired from the OntarioMD EMR Requirements Repository

OMD #	REQUIREMENT	GUIDELINES	M/O	Status	YEAR	YEAR Retired
N/A	N/A	N/A	N/A	N/A	N/A	N/A