

Primary Care Baseline

Requirements

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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 a primary care healthcare setting.

Some of the functional requirements refer to the Ontario Ministry of Health (MOH) guidelines available through various sources, including:

- <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 MOH on its website(s), however, vendors are responsible for obtaining the necessary and most current information to continuously meet the Primary Care Baseline 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 their 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 College of Physicians and Surgeons of Ontario's (CPSO) policies 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

1.1 Scope of the EMR Baseline Requirements

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

1.1.1 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 Management
- Schedule Management
- Referral Management
- Reporting, Query and Communications
- Workflow Management
- Billing Management
- Interface Requirements

1.1.2 Non-functional Requirements

- Data Management
- Implementation Support
- Licensing

1.2 Version History

VERSION	REVISION DATE	NOTES
1.0	2017-08-04	<p>a) Added a new requirement (OMD # 20.02) updated to include the same requirement from the hosting specification which states: "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)."</p> <p>b) The following requirements were changed from Optional to Mandatory because they are supported by all certified vendors:</p> <ul style="list-style-type: none"> • EMR05.07 • EMR05.14 • EMR05.15 • EMR08.05 • EMR11.07 • EMR13.08 • EMR13.09 • EMR13.14 • EMR13.15 • EMR14.11 • EMR14.18 <p>c) Added a new requirement (OMD # 20.01) to have a Threat and Risk Assessment (TRA) conducted on the EMR Offering by an Information Security Professional with the appropriate credentials (e.g., CISSP: Certified Information Systems Security Professional).</p> <p>d) Updated requirement (OMD # 19.01) to state the EMR vendor MUST hold and maintain ISO 13485 certification for the EMR Offering and added guidance that EMR vendors MUST check Health Canada's medical device licensing requirements to determine which version of the ISO 13485 standard is currently required. This requirement was previously specific to ISO 13485:2003. ISO 13485:2016 is now available and Health Canada is giving the industry until March 1st, 2019 to make the transition.</p> <p>e) Changed references to Weighted (W) requirements to Optional (O)</p> <p>f) Removed the interdependencies with documents in previous specifications so that the Primary Care EMR Baseline Requirements can be packaged separately. This required:</p> <ul style="list-style-type: none"> • Removing the "Discrete Data Elements", which are now published in the EMR Core Data Set specification. • Removing cross-references between the functional requirements and the discrete data elements. • Removed requirements EMR18.03 and 18.04, which were duplicates of EMR18.02. <p>g) Updates throughout for use of common terms, capitalization, grammar and spelling</p> <p>h) Updated OntarioMD document template, layout, fonts, colours, etc.</p>
1.1	2019-10-10	<p>a) Updated EMR21.01 to clarify that it includes a TRA</p>

VERSION	REVISION DATE	NOTES
1.2	2020-09-13	<ul style="list-style-type: none"> a) Updated the Specification name (formerly “EMR Primary Care Requirements”) b) All references to the Ministry of Health and Long-Term Care (MOHLTC) have been updated to the Ministry of Health (MOH) c) Updated link to server hardening checklist d) Fixed cosmetic, formatting errors and errata e) Updated CPSO Policies - Medical Records link
1.3	2021-01-18	<ul style="list-style-type: none"> a) Removed section titled “Retired”. b) Updated EMR18.05 to reference the Health Card Validation Reference Manual more consistently. c) Updated EMR19.01 to include ISO 9001 certification as an option to substantiate patient safety within the quality management system.
1.4	2021-01-25	<ul style="list-style-type: none"> a) Removed Specification version in the document title
1.5	2021-09-10	<ul style="list-style-type: none"> a) Updated reference to OHIP Fee Schedule Master b) Moved privacy and security-related requirements out of this specification and into the Privacy and Security Specification c) Re-sequenced requirements: <ul style="list-style-type: none"> i. from EMR15.XX to EMR14.XX ii. from EMR17.XX to EMR15.XX iii. from EMR18.XX to EMR16.XX iv. from EMR19.XX to EMR17.XX d) Added Appendix B – Additional References section to reference related material for: <ul style="list-style-type: none"> i. Cumulative Preventive Care Bonus ii. Ontario's Routine Immunization Schedule e) Corrected various errata
1.6	2023-04-20	<ul style="list-style-type: none"> a) Changed REQ IDs to reflect Specification name (EMR###.## to PC###.##) b) Updated Additional References section: Information and Procedures for Claiming the Cumulative Preventive Care Bonus c) Corrected various errata

1.3 Related Documents, References and Sources

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

DOCUMENT NAME	VERSION	PUBLICATION DATE
Server Hardening Checklist (OntarioMD, 2011) https://www.ontariomd.ca/emr-certification/library/guides-and-references	N/A	2011-01-17
Physician's Guide to Third-Party and Other Uninsured Services (Ontario Medical Association, 2017) https://www.oma.org/ <i>Note: This is a "members only" document (found under the heading "Billing and Agreements")</i>	N/A	2017-01
CPSO Policies - Medical Records Management (College of Physicians and Surgeons of Ontario, 2012) https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Records-Management	NA	2020-03
Ministry of Health (MOH) OHIP Bulletins (Ministry of Health, 2021) <ul style="list-style-type: none"> Preventive Care Chronic Disease Management Primary Care Agreements http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/	N/A	2021-06-04
Technical Specifications – Interface to Health Care Systems Manual (Ministry of Health, 2017) http://www.health.gov.on.ca/en/pro/publications/ohip/	5.0	2017-11-30
OHIP Fee Schedule Master (Ministry of Health, 2023) https://www.health.gov.on.ca/en/pro/programs/ohip/sob/	N/A	2023-04-01
Health Card Validation Reference Manual (Ministry of Health, 2017) http://www.health.gov.on.ca/en/pro/publications/ohip/	1.0	2017-05-02
Processing Enrolment/Consent Forms Reference Manual For Primary Care Groups (Ministry of Health, 2011) http://www.health.gov.on.ca/english/providers/pub/primarycare/proces_e_nrolment/proces_enrolment_mn.html	1.4	2011-04
OLIS Nomenclatures (Ontario Health Digital Services) https://ehealthontario.on.ca/en/olis-nomenclature	Various	Various
Laboratory Requisition (Ministry of Health, 2019) http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ACT=RDR&TAB=PROFILE&ENV=WWE&NO=014-4422-84	2019/01	2019

2. EMR REQUIREMENTS

This section consists of the EMR functional requirements for the Primary Care Baseline Specification.

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

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.

2.1 Demographic Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC01.01	Maintains patient demographic data for rostered patients	Refer to the EMR Core Data Set Standard (CDS-S) Specification for patient demographic data elements.	M	P
PC01.02	Supports the assignment of a patient to the physician roster	Refer to the EMR CDS-S Specification for physician roster data elements.	M	P
PC01.03	Maintains the current and historical enrolment of a patient to a physician	<p>Refer to the EMR CDS-S Specification for patient enrolment history data elements.</p> <p>The definitive patient enrolment to a physician used for payment is kept by the MOH, 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 enroled 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 enroled or non-enrolled.</p> <p>For more information Refer to “Processing Enrolment/Consent Forms Reference Manual - for Primary Care Groups” in the Related Documents section.</p>	M	P
PC01.04	Maintains multiple contacts	<p>Refer to the EMR CDS-S 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>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		Each contact MUST support multiple contact purposes/roles, including Substitute Decision Maker and Emergency Contact.		
PC01.05	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 (HCN) match. HCN version codes MUST be excluded from the matching function. An HCN with a different version code should be considered the same patient record.</p>	M	P
PC01.06	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 duplicate records is a manual function controlled by the EMR user.</p> <p>Automatically merging 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
PC01.07	Provides a means of access to the record of each patient by the patient's name and if the patient has an Ontario HCN by the health number	Based on Ontario Regulation 114/94 (Medicine Act, 1991), Section 20 (2)	M	P
PC01.08	Maintains demographic data for providers	Refer to the EMR CDS-S Specification for provider demographic data elements.	M	P

2.2 Electronic Medical Record (EMR) Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC02.01	Maintains ongoing health conditions, medical problems, and diagnoses	Refer to the CDS-S Specification for ongoing health conditions, medical problems, and diagnosis data elements.	M	P
PC02.02	Maintains past medical and surgical history	Refer to the EMR CDS-S Specification for past medical and surgical history data elements.	M	P
PC02.03	Maintains allergy and adverse reaction data	Refer to the EMR CDS-S Specification for allergy and adverse reaction data elements.	M	P
PC02.04	Maintains family medical history	Refer to the EMR CDS-S Specification for family medical history data elements.	M	P
PC02.05	Maintains medical alerts and special needs	Refer to the EMR CDS-S Specification for alerts and special needs data elements.	M	P
PC02.06	Maintains immunization data	Refer to the EMR CDS-S Specification for immunization data elements.	M	P
PC02.07	Maintains risk factor data	Refer to the EMR CDS-S Specification for risk factor data elements.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC02.08	Maintains care element data	<p>Refer to the EMR Chronic Disease Management Specification for chronic disease data elements.</p> <p>Refer to the EMR CDS-S Specification for generic care data elements.</p>	M	P
PC02.09	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, and Pre-natal checkup.</p>	M	P
PC02.10	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
PC02.11	Provides the ability to modify the medical record of a patient to ensure accuracy in accordance with the 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 Policies - Medical Records” in the Related Documents section.</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC02.12	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"> a) Ongoing Health Conditions data b) Past Medical and Surgical History data c) Past Medical and Surgical History data d) Allergy and Adverse Reaction data e) Family Medical History data f) Alerts and Special Needs data g) Immunization data h) Risk Factors data i) Care Elements data <p>The EMR user 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

2.3 Immunization Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC03.01	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"> a) Patient Name b) Patient Date of Birth c) Patient HCN d) Complete list of Patient's Immunizations e) Immunization Date 	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<p>f) Name of the Primary Physician</p> <p>Primary Physician: In this context, it is the name of the physician accountable for administering the specific vaccine(s) listed in the summary. As such, there may be more than one physician's name listed if the patient had vaccinations administered by different physicians.</p>		
PC03.02	Immunization data entered through EMR data fields is integrated across the EMR Offering	<p>The EMR user should not be forced to re-enter data.</p> <p>Requiring the EMR user to re-enter immunization data 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
PC03.03	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		M	P

2.4 Medication Management

The following terms are defined in this section:

- **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 that 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 that the prescriber has identified as a part of the patient's ongoing treatment plan.

- **Short-term Medications** – A medication that 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 that are no longer part of the patient’s treatment plan.
- **PRN** – A medication that 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
PC04.01	Provides the ability to create patient prescription records	<p>Refer to the EMR CDS-S Specification for medication data elements.</p> <p>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.</p> <p>Prescriptions may be either new or a record of a past prescription.</p>	M	P
PC04.02	<p>Maintains complete documentation of patient medications including:</p> <ul style="list-style-type: none"> • Medications ordered by other healthcare providers • Over-the-counter medications including herbal and nutritional supplements • Past and current medications • Active and inactive prescriptions 	It is important to distinguish that there is a difference between the status of medication in the treatment plan and the status of a prescription for that medication.	M	P
PC04.03	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
PC04.04	Supports the 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

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC04.05	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> <p>Physician information (name, address, phone number) Patient information (name, address, phone number) c) Name of medication d) Strength and strength unit e) Form f) Dosage g) Frequency h) Duration and/or quantity i) Refills j) Refill duration and/or refill quantity k) Start date l) Notes to pharmacist</p> <p>It is acceptable that prescriptions are printed on a standard 8.5 x 11 sheet of paper.</p> <p>If the 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
PC04.06	<p>Performs drug-to-drug interaction checking:</p> <ul style="list-style-type: none"> Indicating severity Allowing override 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
PC04.07	Performs drug-to-allergy and drug-to-intolerance interaction checking:	This decision support tool MUST be a publicly available, commercial off-the-shelf (COTS) drug database.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
	<ul style="list-style-type: none"> Indicating patient allergy severity Allowing override Using an interaction database with Canadian drug codes 	A drug interaction database that is current MUST be used.		
PC04.08	Performs an 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 the:</p> <ul style="list-style-type: none"> a) Drug/condition interactions b) Drug/lab interactions c) Recommended dosing d) Therapeutic alternatives 	O	P
PC04.09	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"> a) 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. b) 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
PC04.10	EMR Offering provides options to manage medication alerting for drug-drug interactions at the organizational level	The EMR Offering MUST have the ability to set the threshold for the display of medication alerts at the organization level.	O	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<p>Additional example workflows may include:</p> <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>		
PC04.11	The EMR Offering provides options to manage medication alerting for drug-to-drug interactions per patient, or per physician.	<p>The EMR Offering MUST have the ability to set the display of medication alerts per patient, or per physician.</p> <p>Settings made per patient, or physician MUST supersede settings made at the physician or organization level.</p> <p>Additional example workflows may include:</p> <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>	O	P
PC04.12	Provides a view of the current medication treatment plan, allowing the ability to change the view of medications between Current, Past, and All	<p>The 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

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC04.13	Presents a patient's medication dosage information over time for an EMR user-selected medication	<p>At a minimum, medication name, dosage, and start date MUST be displayed.</p> <p>The 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
PC04.14	Provides the ability for an EMR user to view the date of the last update to the drug database	<p>At a minimum, the 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
PC04.15	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
PC04.16	Provides the ability to capture a refill quantity and refill duration (days' supply) which differs from the first dispensing	Refer to the EMR CDS-S Specification for medication data elements.	M	P

2.5 Lab Test Management

The following terms are defined for this section:

- **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 2.16 Interface Requirements

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC05.01	Provides the ability to maintain laboratory test results as separate data fields	Refer to the EMR CDS-S Specification for laboratory test data elements.	M	P
PC05.02	The EMR Offering MUST provide a visually distinct method of indicating new laboratory Test Reports through the physician work queue and the patient chart	<p>New test reports are considered to be those that the clinician has received and has not yet opened and/or viewed.</p> <p>At a minimum, the functionality MUST be available to:</p> <ul style="list-style-type: none"> a) The ordering physician b) Copied-to physician(s) 	M	P
PC05.03	The EMR Offering MUST provide a visually distinct indication of abnormal laboratory Test Reports through a physician work queue and the patient chart	<p>At a minimum:</p> <ul style="list-style-type: none"> a) Test Reports MUST display an 'abnormal' flag without opening the actual result b) Test Reports need to be "sortable" such that after being sorted, abnormal lab reports appear at the top of the list 	M	P
PC05.04	The EMR Offering MUST provide a visually distinct indication of which laboratory Test Result(s) within a Test Report is abnormal		M	P
PC05.05	Graphically presents laboratory Test Results and reference ranges over time for EMR user-selected test name	<p>The graph MUST show:</p> <ul style="list-style-type: none"> a) Test Name b) Test Result Value c) Reference Ranges d) Collection Date (if available) <p>Scales MUST be appropriate to the data.</p> <p>THE graph MUST be printable. The printed graph MUST include all data elements referenced in the requirement.</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC05.06	Displays, as data points, EMR user-selected patient medications, or other interventions directly on the graph identified in OMD # PC05.05	The use of mouse hovering or tool tips do not meet the requirement. The printed graph MUST include all data elements referenced in the requirement.	O	P
PC05.07	In a table format, presents laboratory Test Results over time for an EMR user-selected Test Name	The table MUST show: a) Test Name(s) b) Test Results Values c) Collection Date (if available) The table MUST be printable. The printed table MUST include all data elements referenced in the requirement.	M	P
PC05.08	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
PC05.09	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
PC05.10	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 Standard Data Element "DE10.017 – Physician Notes").	M	P
PC05.11	Capable of reconciling laboratory Test Results with orders so that outstanding laboratory tests can be identified	The 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	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		go to a lab). The EMR Offering MUST provide the ability to remove an order from the reconciliation list if desired.		
PC05.12	Laboratory Test Reports/Results can be associated with a specific patient record	Relates to any laboratory tests results received by the EMR Offering: a) Through an interface b) Scanned into the EMR Offering or, c) Manually entered	M	P
PC05.13	Incorporates functionality that allows the EMR user 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
PC05.14	Incorporates functionality that allows the EMR user to cross-reference the EMR Offering's proprietary Test Names to the LOINC Codes as specified in the OLIS Nomenclature	Refer to the "OLIS Nomenclatures" in the Related Documents section.	M	P
PC05.15	Provide the ability to complete the Ontario Lab Requisition Form electronically, prior to printing	<p>The EMR Offering MUST support checking off appropriate boxes, as well as adding text entries within the appropriate sections of the standard form. The creation of the lab requisition form 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.</p> <p>The clinician's (e.g., physician's, nurse practitioner's) signature is still required on the completed (printed) form.</p> <p>Standard laboratory requisition forms may be updated at MOH discretion and EMR Offerings are required to conform to the most recent update.</p> <p>Refer to the "Laboratory Requisition" in the Related Documents section for the most current laboratory requisition form available.</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC05.16	Automatically populates and prints the demographic information for patient and physician in the appropriate fields on the Ontario Lab Requisition Form	<p>The laboratory requisition form may be updated at the MOH's discretion. EMR Offerings are required to conform to the most recent update.</p> <p>Refer to the "Laboratory Requisition" in the Related Documents section for the most current laboratory requisition form available.</p>	M	P
PC05.17	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
PC05.18	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

2.6 External Document Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC06.01	Able to import external documents to become part of the EMR Offering	<p>Refer to the EMR CDS-S Specification for report data elements.</p> <p>Relates to any external document received by the EMR Offering:</p> <ul style="list-style-type: none"> a) Through an interface b) 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
PC06.02	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

2.7 Cumulative Patient Profile (CPP) Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC07.01	Displays Cumulative Patient Profile (CPP), identifying the summary of patient information	<p>At a minimum, the CPP displays the following categories:</p> <ul style="list-style-type: none"> a) Ongoing Health Conditions b) Past Medical and Surgical History c) Family Medical History d) Immunization Summary e) Allergies and Adverse Reactions f) Medication Summary g) Risk Factors h) Medical Alerts and Special Needs 	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<p>Refer to requirements PC07.02 through PC07.08 regarding CPP categories.</p> <p>Refer to the “CPSO Policies - Medical Records” for information about the CPP.</p>		
PC07.02	Displays Ongoing Health Conditions	Referenced also as ongoing (current) Health Condition or Diagnosis List.	M	P
PC07.03	Displays Past Medical and Surgical History		M	P
PC07.04	Displays Family Medical History		M	P
PC07.05	Displays Allergies and Adverse Reactions		M	P
PC07.06	Displays Medications summary	Can display an ongoing medication treatment plan as the default. Can also include current acute medications.	M	P
PC07.07	Displays Risk Factors		M	P
PC07.08	Displays Medical Alerts and Special Needs		M	P
PC07.09	Provides a method of re-ordering/sorting the CPP items at the EMR user’s discretion	<p>The EMR 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"> a) Ongoing Health Conditions b) Past Medical and Surgical History c) Family History d) Allergies and Adverse Reactions e) Medication Summary f) Risk Factors g) Medical Alerts and Special Needs 	O	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<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>		
PC07.10	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
PC07.11	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"> a) Add and remove CPP categories for display b) 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
PC07.12	SHOULD be able to support additional customizations of the CPP	<p>Accepted solutions include (but are not limited to):</p> <p>Resizing CPP categories to optimize data display and scrolling</p> <p>Any customizations MUST be maintained in subsequent logins by the EMR user.</p>	O	P
PC07.13	CPP can be printed to a single document as a single operation	<p>Sections of the CPP MUST be identifiable within the printed document.</p> <p>The printed document MAY exceed one page.</p>	M	P

2.8 Encounter Documentation Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC08.01	Provides forms or templates for common encounters that can be modified by an EMR user	Examples: SOAP (Subjective, Objective Assessment Plan), Annual Physical, Ante-natal, etc.	O	P
PC08.02	Automatically includes an EMR user identifier in each part of the encounter note to support the shared creation of encounter documentation	<p>The following would NOT meet the requirement:</p> <ul style="list-style-type: none"> a) Manual entry of identification (e.g., initials) b) Comparing encounter note versions to identify what information was entered by an EMR user c) Requiring the EMR user to access audit logs to view entry information <p>Allowing the EMR user to toggle identifying information within the encounter note view is acceptable if the identifier information can be retrieved.</p>	M	P
PC08.03	Supports free-form text notes that are tied to each encounter		M	P
PC08.04	Provides the ability to view and print all encounter documentation in chronological order	Based on Ontario Regulation 114/94, Section 20 (4).	M	P
PC08.05	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
PC08.06	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
PC08.07	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 indicates multiple activities within a single office visit.	M	P

2.9 Schedule Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC09.01	Maintains appointment data	Refer to the EMR CDS-S Standard Specification for appointment data elements.	M	P
PC09.02	Provides the ability to flag appointments as critical (visually distinct)		M	P
PC09.03	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: a) The patient's HCN b) Service date	M	P
PC09.04	Able to open a patient's medical record directly from a scheduled appointment without having to perform another search for the patient		M	P
PC09.05	Supports the 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
PC09.06	Supports searching for the next available appointment by all of the following in a single function: <ul style="list-style-type: none">PhysicianDay of the weekTime of dayAppointment type	MUST be an online function, not a report.	M	P
PC09.07	The schedule is printable as a day-sheet sorted alphabetically by patient name.		M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC09.08	The schedule is printable as a day-sheet sorted chronologically	The day-sheet should be in ascending order (i.e., the earliest time should appear at the top of the sheet).	M	P
PC09.09	The schedule is printable as a day-sheet sorted by chart number		O	P
PC09.10	Supports pre-configuration of schedule slots or blocks by the physician		O	P
PC09.11	Supports planned periods of multiple appointments to a single start time	Ad hoc double booking does not meet the requirement. MUST be: a) Visually distinct b) Preplanned and configured c) Able to search for the next available slot or overbooking occurs only after the planned period is full	O	P
PC09.12	Supports ad hoc double booking that is: <ul style="list-style-type: none"> 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
PC09.13	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
PC09.14	Supports drag and drop rescheduling	Can be cut and pasted, or any other means of rescheduling without a delete and add process.	O	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC09.15	Supports the display of the status of the patient in the clinic	The EMR Offering MAY have pre-defined status definitions or allow for EMR user-defined status.	M	P
PC09.16	Provides the ability for a physician to view and modify their schedule		M	P
PC09.17	Provides a view for appointment history for any given patient in the EMR Offering	The view includes both past and future appointments.	M	P

2.10 Referral Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC10.01	The EMR Offering supports referral letter templates specific to specialty	<p>The letter templates MUST:</p> <ul style="list-style-type: none"> a) Integrate patient demographics (i.e., name, age, DOB, gender, HCN, patient contact information) from the EMR Offering b) Include the physician's letterhead and contact information c) Referring physician's name and contact information d) 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"> a) Saved in their original form b) The date saved is the date the letter was generated c) Updates made to the patient medical data after letter generation MUST not affect and update the saved letter 	M	P
PC10.02	The EMR Offering tracks referrals and provides a reminder, if outstanding	<p>Reminders MUST:</p> <ul style="list-style-type: none"> a) Be visually distinct b) Be in the patient record c) Identify referral physician d) Be turned off at EMR user discretion 	M	P

2.11 Reporting, Query and Communications

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC11.01	All EMR data MUST be able to be produced in a hard copy format	<p>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 Policies - Medical Records” in the Related Documents section.</p>	M	P
PC11.02	<p>Allows the EMR user to set up preventive care parameters required for the Patient Recall List and Cumulative Bonus Report generation for each of the five preventive care categories:</p> <ul style="list-style-type: none"> • Mammogram • Pap smear • Colorectal • Immunization • Influenza 	<p>The EMR user MUST be able to set up and maintain the following parameters for the target populations:</p> <ol style="list-style-type: none"> Enrolment status Age Gender Procedure/vaccination timeline Exclusion codes <p>The parameters applicable MUST be adjustable and saved:</p> <ol 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 MOH for applicable Physician Group Agreements. See the OHIP Bulletins and MOH guidelines.</p>	M	P
PC11.03	Generates the Patient Recall List report for preventive care activities/programs for patients enroled to a physician	<p>Patient Recall List MUST include/indicate:</p> <ol style="list-style-type: none"> Target population The physician to whom the patient is enroled Patient information (name, HCN, 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 	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<p>f) Last procedure date</p> <p>g) Last date of communication (printed letters or phone call)</p> <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 the EMR 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 MOH for applicable Physician Group Agreements. See the OHIP Bulletins and MOH guidelines.</p>		
PC11.04	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"> a) Generate the letters in a batch and individually (both MUST be supported) b) Generate the letters without requiring the EMR user to do another patient lookup c) Save records of all correspondence including dates of delivery of the written notices <p>Letters MUST meet requirements listed in the MOH Service Enhancement Codes Primary Care Agreements:</p> <ul style="list-style-type: none"> a) Indicate whether it is the first or second written notice b) Indicate the procedure type, benefits and the date of the last procedure c) The name and address of the patient or guardian (for Childhood Immunizations) d) Physician letterhead and information (name, address, phone number) 	M	P
PC11.05	Generates Cumulative Bonus reports for preventive care activities/programs for patients enroled to a physician	<p>Cumulative Bonus report MUST include/indicate:</p> <ul style="list-style-type: none"> a) The target population b) The physician to whom the patient is enroled c) Patient information (name, HCN, age, gender) 	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<p>d) Last procedure date</p> <p>e) Whether the eligible patients for the selected fiscal year have received the procedure or not</p> <p>f) Percentage of patients who have received the procedure from the target population</p> <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 EMR 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 MOH for applicable Physician Group Agreements. See the OHIP Bulletins and MOH guidelines.</p>		
PC11.06	Provides a report writer that 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 user-friendly.</p>	M	P
PC11.07	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> <p>a) Coding schemas</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		b) Drop-down lists, etc.		
PC11.08	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
PC11.09	Able to search and report on ALL data fields in the EMR Offering	Image data is not required.	M	P
PC11.10	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
PC11.11	Provides report templates for EMR data that may be modified by the EMR user		O	P
PC11.12	Allows for the identification of static cohorts of patients for chronic disease or other tracking	To satisfy this requirement the physician MUST be able to define the name and population of their 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
PC11.13	EMR Usage Metrics Report	Report indicates: a) Physician for whom the report is being generated b) Date range of report c) Practice profile information d) Metrics for the patients rostered to physician i) scheduled appointments ii) billing (OHIP, WSIB, private, uninsured) iii) encounter notes created iv) problems entered in the Ongoing Health Condition list v) stored documents (including scanned documents or external documents received from an interface)	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		vi) new and renewed prescriptions vii) lab test results received electronically viii) alerts/reminders generated Refer to section 3.1 - EMR Usage Metrics Report (Req # PC11.13) - Sample.		

2.12 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
PC12.01	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
PC12.02	Supports the classification of task priority	Priority can be indicated by urgent, low, etc., or a priority checkbox.	M	P
PC12.03	Supports free-form text notes that are tied to each task		M	P
PC12.04	Provides the ability to associate a task with a laboratory Test Report/Result	Laboratory Test Report/Result can be opened from the task. Assigned the EMR user's access to lab information MUST follow appropriate security permissions for that EMR user.	O	P
PC12.05	Provides the ability to associate a task with an external document	Document records can be opened from the task. Assigned EMR user's access to documents MUST follow appropriate security permissions for that EMR user.	O	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC12.06	Supports the creation of new ad hoc tasks and their assignment to other specified EMR users		M	P
PC12.07	Supports the creation of new ad hoc tasks and their assignment to others by role		M	P
PC12.08	Tasks can be created, accessed, and actionable anywhere in the application.		M	P
PC12.09	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
PC12.10	Work queue screens can be customized for different roles	Work queues can be customized by roles such as nursing, physicians, receptionists, etc.	O	P
PC12.11	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"> a) Outstanding lab requests, and other tests (e.g., Diagnostic Imaging) b) 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
PC12.12	Automatically creates a task for past-due targeted health maintenance activities and assigns it to a pre-defined work	<p>Running a query to generate tasks on all applicable records is acceptable.</p> <p>The EMR user should be able to assign/redirect tasks to a particular EMR user</p>	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
	queue; the tasks MUST be generated by the EMR Offering, not created by an EMR user	<p>or role.</p> <p>The EMR user should be able to turn off this functionality.</p> <p>See the OHIP Bulletins and MOH guidelines.</p>		
PC12.13	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"> a) Reports received through an interface b) Reports scanned into the EMR Offering c) Reports manually keyed <p>A mandatory concurrent entry MUST be present in the physician's "inbox" for sign-off.</p>	M	P
PC12.14	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"> a) Encounter documentation b) 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"> a) Visible in the patient's chart b) Captured in the audit log 	M	P
PC12.15	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

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC12.16	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"> a) Encounter documentation b) 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"> a) Visible in the patient's chart b) Captured in the audit log <p>Only 1 copy of the report is posted to the patient’s chart.</p>	M	P
PC12.17	Provides functionality from the “inbox” to allow the EMR user to re-display an item that has been signed-off	<p>This applies to all patient information signed off, such as:</p> <ul style="list-style-type: none"> a) Reports received through an interface b) Reports scanned into the EMR Offering c) 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

2.13 Billing Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC13.01	Processes concurrent Ontario billings models of fee-for-service, shadow partial payment billings, and Physician Group bonus codes	See the OHIP Bulletins and MOH guidelines.	M	P
PC13.02	Provides basic error checking. MUST alert the EMR user when an error is detected.	At a minimum, the basic error checking to be provided when: Registering patients: a) Ontario HCN - check digit, b) HCN duplicate Edits for all mandatory billing fields: a) Service date b) Physician number c) HCN d) Name e) Date of Birth (DOB) f) Gender g) Fee code and fee claimed h) Checks all dates are valid dates and in the past	M	P
PC13.03	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 MOH-defined data fields, based on their MRO record type. Supports the resubmission of rejected claims without the need to re-enter data. See the OHIP Bulletins and MOH guidelines.	M	P
PC13.04	Supports reading a health card through a card reader device and looking up the patient in the EMR application database	The EMR Offering MUST: a) Notify of version code discrepancies, and	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		b) Upon EMR user request, automatically update the patient record with demographic data associated with the HCN <ul style="list-style-type: none"> • Name • Gender • DOB 		
PC13.05	Supports WSIB billing through MRI files		M	P
PC13.06	Can create a claim directly from the patient encounter information	MUST transfer all pertinent billing data that is present in the clinical record. Pertinent data includes, but is not limited to: <ul style="list-style-type: none"> a) Patient information b) Physician information c) Service date d) Procedure code e) Diagnosis code f) Location g) Clinic/hospital number 	O	P
PC13.07	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
PC13.08	Supports manual entry of non-OHIP billing transactions including: <ul style="list-style-type: none"> • Direct to patient • Reciprocal • 3rd party 		M	P
PC13.09	Provides aged receivables listing for all billing types (not just OHIP)	The list MUST indicate: <ul style="list-style-type: none"> a) Patient ID b) Service provided 	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		c) Service date d) Outstanding amount Any ageing buckets are acceptable. Can be any report to manage outstanding claims.		
PC13.10	Contains the current OHIP fee schedule including preventive care codes		M	P
PC13.11	Maintains and uses a historical OHIP fee schedule for the prior year	Prior fee schedule information may be required for resubmission purposes.	M	P
PC13.12	Provides lookup of services and diagnoses by their codes as well as their descriptions		M	P
PC13.13	Forces reconcilable disposition of all scheduled appointments (i.e., provides a screen or report that lists patient appointments that have no billings)	The EMR user MUST take some action to remove unbilled appointments from the list. Deleting appointments does not meet the requirement.	M	P
PC13.14	Supports direct third-party billings with invoices	Able to be generated on demand. At a minimum, the third-party billings with invoices MUST include: a) Physician name b) Patient name or ID c) Payor address d) Service date e) Service f) Itemized amount(s) g) Total amount billed	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC13.15	Supports direct third-party billings with statements	<p>Able to be generated on demand.</p> <p>At a minimum, the third-party billings with statements MUST include:</p> <ul style="list-style-type: none"> a) Physician name b) Patient name or ID c) Payor address d) Service date e) Service f) Itemized amount(s) amount paid g) Balance <p>Receipts are not sufficient.</p>	M	P
PC13.16	<p>Supports billing lookup by each of the following:</p> <ul style="list-style-type: none"> • Patient HCN • Patient name • OHIP claim # or Accounting # 	<p>OHIP claim # is assigned by the OHIP claims payment system.</p> <p>Accounting # is assigned by EMR Offering or EMR user to a claim.</p>	M	P
PC13.17	Enables updating of billing codes through the OHIP fee schedule master update file as provided by MOH in the specified format	Refer to the "OHIP Fee Schedule Master" in the Related Documents section.	M	P
PC13.18	Notifies the EMR user of changes to billing codes per the updates in the fee schedule master	<p>At a minimum, notifications MUST be provided for:</p> <ul style="list-style-type: none"> a) Updated Fees b) Updated Effective Date c) Updated Expiration Date d) New billing codes 	O	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC13.19	Provides access to OMA-suggested fees for uninsured services and third-party services, including HST eligibility	<p>OMA services and third- Suggested Fees for uninsured party services can be accessed from scheduling and billing modules, and the patient's medical record.</p> <p>Refer to "Physician's Guide to Third-Party and Other Uninsured Services" published by the OMA for a list of suggested fees for uninsured services and third-party services.</p>	M	P
PC13.20	Provides the capability of correcting a billing entry error without classifying it as a write-off	<p>A 'write-off' implies an uncollectable amount. These amounts should be coded and treated as such.</p> <p>An 'error' is an honest error and should be treated as such.</p> <p>Write-offs and errors should be associated with a reason code/reason description.</p> <p>Report(s) that show write-offs and error corrections should show each.</p>	M	P

2.14 Data Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC14.01	MUST retain medical records information	<p>It is recommended to maintain records for a minimum of 15 years.</p> <p>Refer to the "CPSO Policies - Medical Records" in the Related Documents section.</p>	M	P
PC14.02	MUST retain billing transaction details for at least seven years	This standard may be updated by MOH.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC14.03	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	The vendor MUST provide substantiation that databases with inherent limitations, such as MSDE or MS Access, can meet this requirement.	M	P
PC14.04	Provides a complete system (applications and data) backup and recovery process	Based on Ontario Regulation 114/94, Section 20 (7). Back-up can be full or incremental, etc. Recovery can be to the last backup, point of failure, etc.	M	P
PC14.05	External documentation MUST be stored using a database solution	Refer to the external documentation described in section 2.6 External Document Management A solution that stores documents in the file system (server or client) only does not satisfy the requirement.	O	P
PC14.06	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
PC14.07	Harden the EMR server in preparation for server-level encryption	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. Physical security is elevated when all application data and information is encrypted. This guideline does not apply to Hosted EMR Offerings. Refer to the "Server Hardening Checklist" in the Related Documents section.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC14.08	An anti-malware solution and EMR Offering MUST be able to co-exist without conflicts	The 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

2.15 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
PC15.01	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
PC15.02	Provides additional EMR Offering support (e.g., 7 x 24 support)		O	P
PC15.03	The EMR vendor is able to troubleshoot common technical/user issues via electronic/remote support	To satisfy this requirement, the EMR vendor MUST be able to provide support by viewing the 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 for the privacy and security of Personal Health Information.	M	P
PC15.04	The EMR vendor is able to remotely provide simple upgrades and code corrections	To satisfy this requirement, the EMR vendor MUST be able to: a) Push updates and administrator to download, accept and execute b) Schedule a time with the user and make updates remotely	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC15.05	The EMR user documentation is available in electronic format	<p>The documentation MUST be comprehensive of all available EMR functionality.</p> <p>To satisfy this requirement, documentation MUST either be distributed to or made available for download by customers.</p> <p>The document MUST be searchable.</p>	M	P
PC15.06	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 searching does not satisfy this requirement.</p>	O	P
PC15.07	Offers EMR training	At a minimum, training MUST be offered on all functionalities described in this specification.	M	P

2.16 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
PC16.01	Claims and Incentive Payments through the MOH Billing system	Refer to the “Technical Specifications – Interface to Health Care Systems” in the Related Documents section.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC16.02	Commercial Laboratories – MUST support at least one of the following: <ul style="list-style-type: none"> • 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
PC16.03	The EMR Offering MUST support validation of Ontario health cards through the MOH using at least one of the following: <ul style="list-style-type: none"> • OBEC (Overnight Batch Eligibility Checking) • HCV (Real-Time Health Card Validation) 	Refer to the Health Card Validation Reference Manual.	M	P

2.16.1 Claims and Incentive Payments

The MOH 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 in the “Technical Specifications – Interface to Health Care Systems” referenced in the Related Documents section.

2.16.2 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 its 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 – www.lifelabs.com

2.16.3 Health Card Validation

The MOH Health Card Validation (HCV) system allows healthcare 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 HCV access options, as well as contact information for testing the interface, can be found in the “Health Card Validation Reference Manual” in the Related Documents section.

2.17 Licensing Requirements

This section consists of the requirements for the licensing of EMRs.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC17.01	The EMR vendor MUST have a quality management system (QMS) that includes patient safety within its definition of quality	<p>The EMR vendor MUST provide either:</p> <ul style="list-style-type: none"> a) a current ISO 13485 certificate, or b) a current ISO 9001 certificate + provide an excerpt of the audited quality documentation (e.g., quality manual) that demonstrates the concept of patient safety (i.e., patients’ freedom from unacceptable risk) was included in the description of: <ul style="list-style-type: none"> i) the needs and expectations of interested parties (ISO 9001:2015 Requirement 4.2) and ii) the scope of the quality management system (ISO 9001:2015 Requirement 4.3). 	M	P

3. APPENDIX A: SUPPORTING INFORMATION

3.1 EMR Usage Metrics Report (Req # PC11.13) - 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) 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, and diagnoses from CPP
4. Store documents not originating from the practice; including 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

4. APPENDIX B: ADDITIONAL REFERENCES

The following is a table of supporting documentation and recommended reading.

ID	NAME	VERSION	DATE
1	<p>Information and Procedures for Claiming the Cumulative Preventive Care Bonus (Ministry of Health, 2023)</p> <p>https://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/11000/bul11235_info.pdf</p> <p><i>Note: Refer to the MOH bulletins for the most current information available</i></p>	N/A	2023-03
2	<p>Ontario's Routine Immunization Schedule (Ministry of Health, n.d.)</p> <p>https://www.health.gov.on.ca/en/public/programs/immunization/static/immunization_tool.html</p>	N/A	N/A