

**California Department of Mental Health
BH-EHR Requirements Survey
Company Information**

Please provide the following information about your organization.	
Company Name	Cerner Corporation
Company Address	2800 Rockcreek Parkway Kansas City, MO 64117
Company Web Site	www.cerner.com
Product Name(s)	Cerner Millennium
Product Description(s)	For a complete listing of Cerner Millennium Solutions and descriptions, please refer to the Solution List Excel document located in Appendix A of our response.
Primary Contact Name	Jodi Drury
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Date of Response	12/5/2008

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Infrastructure - Cerner Corporation

<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
F-35	35.001	The system shall be able to audit the date / time and user of each instance when a client's health information is printed by the system.	Does not include screen print and other functions that are external to the programmed functionality of the EHR system.	1						
F-35	35.002	The system shall provide a means to document a client's dispute with their health information currently in the system.	Clients review of their health information may be through on-screen viewing or by printing of their health information. This requirement does not require the client shall document their dispute directly into the system. Methods to document their dispute include direct text entry, scanned copying of client comments, or any other authorized method.	1						

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F-35	35.003	The system shall be able to identify all users who have accessed an individual's health information over a given time period, including date and time of access.	Specific items / sections of information accessed shall be identified, with appropriate audit trail.	1						Cerner's auditing solution was designed in response to HIPAA privacy and security provisions, among other considerations, allowing the audit of user actions as patient-identifiable information is accessed. This information includes data identifying the user, the patient, the context of the access, and the actions performed to the patient data, including actions that create, verify, modify, complete, amend\error correct, and print patient information.
F-35	35.004	The system shall be able to identify certain information as confidential and only make that accessible by appropriately authorized users.	This may be implemented by having a "confidential" section of the client's health information.	1						

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F-35	35.005	The system shall be able to prevent specified user(s) from accessing some or all of a designated client's health information.	An example would be preventing access to a VIP or staff member's health information. When access is restricted, the system shall provide a means for appropriately authorized users to "break the glass" for emergency situations. Such overrides shall be audited.	1						
F-36	36.001	The system shall be able to retain and retrieve client health information until purged, deleted, archived or otherwise deliberately removed.		1						
F-36	36.002	The system shall provide a method for archiving client health information, and all supporting electronic files (including application software files).	Archiving is used to mean information stored in a retrievable fashion without defining where or how it is stored.	1						P2 Sentinel supports archiving via EMC's Centera. P2 Sentinel uses Centera APIs that allow the Centera data store to appear as local storage. Data archival can be a manual or scheduled process determined by the administrator of the system.
F-36	36.003	The system shall be able to retrieve information that has been archived.	Retrieval does not imply restoration to current version of the software.	1						
F-36	36.005	The system shall be able to retain imported client health information, as originally received (unaltered, inclusive of the method in which they were received).	Implies retention for the legally prescribed time frames.	1						

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F-36	36.006	The system shall be able to retrieve information in a manner conducive to recreating the context in which the information was obtained.		1						
F-36	36.007	The system shall be able to store and retrieve all the elements included in a legal health (medical) record.		1						
F-36	36.008	The system shall provide for oversight, review and confirmation of record(s) destruction prior to destroying specific EHR data / records.		1						Patient data stored within the Cerner Millennium database is not deleted.
F-36	36.009	The system shall be able to destroy EHR data / records so that all traces are unrecoverable.		1						Millennium contains a purge function that allows a client to establish purge criteria for data that is no longer required.
F-37	37.001	The system shall be able to log exported client health information in an auditable form.							1	All Millennium that is relevant for clinical care is kept online.
F-37	37.002	The system shall be able to log the receipt of client health information in an auditable form.		1						

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F-37	37.004	The system shall allow administration, over which system components will have audit controls in place and what types of audit trails are utilized.	Examples of audit trails include: tracking record additions, edits, and deletions, record access, etc.	1						You can perform an audit trail query to access data specific to the patient's record or chart, who accessed it successfully, the date and time of the attempt, and information regarding the access event including events that changes or modify patient information. It should be noted that any actual state change to patient data is considered part of the clinical record, and the history of any such change is maintained within the patient's record.
F-38	38.001	The system shall be able to export client related health information from the system.	Examples of client related health information include: Performance measurements, chronic disease data, etc.	1						
F-38	38.002	The system shall be able to import client related health information into the system		1						

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F-38	38.003	The system shall allow removal of discrete client identifiers.	De-identification is necessary for research purposes, e.g., to identify patterns of disease. External applications can be used to meet this criterion.	1						
F-38	38.004	The system shall be able to specify the intended destination of the extracted information.	The user may indicate to whom they are sending results. The lack of control of information once it leaves the practice is acknowledged.	1						
F-39	39.001	The system shall allow multiple users to interact concurrently with the EHR application.		1						
F-39	39.002	The system shall allow concurrent users to simultaneously view the same client health information or EHR related information.	Examples of other EHR related information includes: clinical, administrative, or financial reports / analyses and documentation templates.	1						
F-39	39.004	The system shall provide protection to maintain the integrity of client health information during concurrent access.	Implies protection against simultaneous record update attempts with resultant loss of data	1						

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F-39	39.005	The system shall trigger alerts to simultaneous users of each other's presence in the same data record.							1	In the event that more than one user attempts to update the same field at the same time, the system will lock the field and allow one user to make their change, and then unlock it for the next user to change. The changes are sequential rather than concurrent, averting the situation of a locked chart. This feature works regardless of the type of change being made.
F-43	43.013	The system shall support the downloading, uploading and secure connection for mobile workforce and remote users.		1						
F-43	43.038	The system shall be scalable to meet current and future user access and data storage needs.		1						
F-43	43.039	The system shall incorporate a consistent user interface (UI) for manual and imported data entry.	Implies the UI design should be independent of the proposed hardware configuration.	1						

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F-43	43.040	The system shall support a variety of data input methods.	Examples of data input include: Voice recognition, Voice dictation, Touch screen, Light pen, Mouse, Keyboard, Electronic tablet, Scanning, Audio files, Optical character recognition, electronic receipt of information (e.g., remote data entry, data file or record uploads, Etc.), "Cut and Paste" or "Copy and Paste", Etc. Implies support for compliance with Americans with Disabilities Act (ADA) requirements.	1						
F-43	43.041	The system shall support remote system monitoring technology.		1						
F-43	43.042	The system shall incorporate extensive, secure capabilities that link staff from remote locations to the central site.	Staff is general in nature and includes office support and administrative related staff as well as medical service providers.	1						
F-43	43.048	The system shall support and implement redundancy / fault tolerance for 100% system availability.		1						
F-43	43.049	The system shall support secure Web-based system access.		1						
F-43	43.050	The system shall manage both structured and unstructured health record information during manual and electronic, retrieval, update, reporting, and tracking processes.	Management of actions involving complete or partial records is included.	1						
F-43	43.051	The system shall support efficient linkage of all associations between structured and unstructured health record information.	Includes structured to structured, unstructured to unstructured, and structured to unstructured data associations.	1						

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S-01	1.001	The system shall provide support for assigning users role-based system access.	Examples of support include: Assigning access by User identity, User role, User work assignment, Group work assignments, Client's health condition, and Work Context such as time of day or user / client location(s), etc.	1						
S-01	1.002	The system shall provide the ability for authorized system administrators to add / delete users and assign, modify, or delete related system access restrictions or privileges.	Implies users are human beings or software applications.	1						
S-01	1.004	The system shall maintain a history of system users.		1						
S-01	1.018	The system shall provide the ability to define user access to the application's functions.		1						
S-01	1.019	The system shall require user login passwords be changed regularly.		1						
S-01	1.020	The system shall provide timely support for user password updates.	Examples of timely support include: 1) Automatic notifications to users upon successful access to the application that the current password is due to expire. 2) System Administrator sets how many days prior to password expiration a user will receive related notification.	1						

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S-01	1.022	The system shall require valid and secure user login passwords structured.		1						Cerner functionality provides the ability for you to define the minimum number of total characters in a password, the minimum number of alpha characters, minimum number of numeric characters, minimum number of special characters, and whether case sensitivity is to be honored.
S-01	1.023	The system shall provide the ability to automatically log users out of the system after a period of inactivity.		1						
S-01	1.024	The system shall comply with client confidentiality and privacy.		1						
S-01	1.026	The system shall allow a user to mark a client's specific health information as blinded, prohibiting access to other users.		1						
S-01	1.027	The system shall support access to blinded information to a treating healthcare service provider, when the blinded information is necessary for managing an emergency condition.	Note: This is commonly known as a "break the glass" function. This does not provide permanently increasing access rights for the healthcare service provider.	1						

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S-01	1.028	The "break the glass" function must be capable of requiring the healthcare service provider requesting access to blinded information to document and record the reason(s) for requesting access.		1						
S-02	2.001	The system shall authenticate the user before any access to Protected Resources (e.g. PHI) is allowed, including when not connected to a network e.g. mobile devices.		1						
S-02	2.004	The system shall enforce a limit of consecutive invalid access attempts by a user. The system shall protect against further, possibly malicious, user authentication attempts.	Examples of protection against further authentication attempt include: Locking the account / node until released by a System Administrator, locking the account / node for a configurable time period, or delaying the next login prompt according to a flexible delay algorithm.	1						
S-02	2.005	The system shall provide an administrative function that resets passwords.		1						
S-02	2.006	The system shall require the user to change the password after their next successful login when their login account has been reset by a System Administrator .		1						
S-02	2.007	The system shall provide only limited feedback information to the user during login authentication.		1						

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S-02	2.008	The system shall support case-insensitive usernames that contain typeable alphanumeric characters in support of ISO-646 / ECMA-6 (aka US ASCII).		1						
S-02	2.009	The system shall allow an authenticated user to change their password consistent with password strength rules.		1						
S-02	2.010	The system shall support case-sensitive passwords that contain typeable alphanumeric characters in support of ISO-646 / ECMA-6 (aka US ASCII).		1						
S-02	2.011	The system shall not store passwords in plain text.		1						
S-02	2.012	The system shall prevent the reuse of passwords previously used within a specific (configurable) timeframe (i.e., within the last X days, etc. - e.g. "last 180 days"), or shall prevent the reuse of a certain (configurable) number of the most recently used passwords (e.g. "last 5 passwords").		1						

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S-02	2.015	The system shall provide the ability to implement Chain of Trust agreements.		1						Both users and applications are subject to authentication. The EHR-S must provide mechanisms for users and applications to be authenticated. Users will have to be authenticated when they attempt to use the application, the applications must authenticate themselves before accessing EHR information managed by other applications or remote EHR-S'. In order for authentication to be established a Chain of Trust agreement is assumed to be in place. Examples of entity authentication include: > Username/ password; > Digital certificate; > Secure token; > Biometrics Essential Now 5 Authentication is the first step in Cerner Millennium security. To be authenticated means that the system knows who you are and that you

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S-02	2.016	The system shall support, at a minimum, two-factor authentication in alignment with NIST 800-63 Level 3 Authentication.		1						NIST 800-63 – Electronic Authentication Guideline – Paraphrasing from the document, this document provides guidelines for selecting technology based on e-authentication technical guidance. The guideline specifically states that “these guidelines provide technical recommendations for the process of authentication not authorization”. The guideline describes four levels of authentication. The Cerner Millennium system supports both Level 1 and Level 2 as described within this guideline. There is currently a project scheduled to implement support of Level 3 as described within this guideline. Currently, no Cerner Millennium clients have expressed the need for Level 4 authentication as described within this

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S-02	2.017	The system shall not export passwords in plain text.		1						
S-02	2.018	The system shall not display passwords while being entered.		1						
S-03	3.001	The system shall include documentation available to the customer that provides guidelines for configuration and use of the EHR System security controls necessary to support secure and reliable operation of the system, including but not limited to: creation, modification, and deactivation of user accounts, management of roles, reset of passwords, configuration of password constraints, and audit logs.		1						
S-04	4.001	The system shall support protection of confidentiality of all Protected Health Information (PHI) delivered over the Internet or other known open networks via encryption using triple-DES (3DES) or the Advanced Encryption Standard (AES) and an open protocol such as TLS, SSL, IPSec, XML encryptions, or S/MIME or their successors.		1						Cerner Millennium supports the ability to interoperate with the use of TLS or SSL types of network communication security as are applicable.

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S-04	4.004	The system shall include the capability to encrypt the data communicated over the network via SSL (HTML over HTTPS) for systems that provide access to PHI through a web browser interface (i.e. HTML over HTTP) .	Note: Web browser interfaces are often used beyond the perimeter of the protected enterprise network	1						
S-04	4.005	The system shall support protection of integrity of all Protected Health Information (PHI) delivered over the Internet or other known open networks via SHA1 hashing and an open protocol such as TLS, SSL, IPsec, XML digital signature, or S/MIME or their successors.		1						
S-04	4.006	The system shall support ensuring the authenticity of remote nodes (mutual node authentication) when communicating Protected Health Information (PHI) over the Internet or other known open networks using an open protocol (e.g. TLS, SSL, IPsec, XML sig, S/MIME).		1						
S-04	4.007	The system, when storing PHI on any physical media intended to be portable / removable (e.g. thumb-drives, CD-ROM, PDA), shall support use of a standards based encrypted format using triple-DES (3DES), and the Advanced Encryption Standard (AES).							1	Patient information is not stored on the client machines.

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S-04	4.008	The system shall have security measures to protect data being transmitted via wireless networks, including data communications with portable devices.		1						There are several EAP security schemes currently available, including PEAP, EAP-TLS, LEAP, EAP-TTLS, etc.
S-04	4.009	The system shall provide the ability to obfuscate (intentionally make difficult to read) data.		1						Across the LAN, only the user's password is encrypted. Across the WAN/Internet, all data is encrypted via Citrix. Cerner does not encrypt data at rest in the database.
S-04	4.013	The system shall provide the ability to link data entry by a user to another user per defined "Role Based" relationships.	For example: a student or trainee is not authorized to release data in a client's EHR, but may enter it. The supervisor or trainer must review and release the data. The supervisor or trainer's identifier must be stored with the released data.	1						
S-04	4.014	The system shall support the storage of any Protected Health Information (PHI) data on any associated mobile device(s) in an encrypted format.	Implies encryption is via triple-DES (3DES), the Advanced Encryption Standard (AES), or their successors. . Examples of mobile devices include: PDAs, smart phones, etc.						1	Patient information is not stored on the client machines.
S-04	4.015	The system, prior to a user login, shall display a warning notice (e.g. "The system should only be accessed by authorized users").		1						You can modify the Cerner splash screen which accepts the Millennium username and password.

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S-04	4.016	The system shall be able to support time synchronization using NTP / SNTP, and use this synchronized time in all security records of time.		1						
S-04	4.017	The system shall have the ability to format for export recorded time stamps using UTC based on ISO 8601. Example: "1994-11-05T08:15:30-05:00" corresponds to November 5, 1994, 8:15:30 am, US Eastern Standard Time.		1						
S-05	5.001	The system shall support logging to a common audit engine using the schema and transports specified in the Audit Log specification of IHE (Integrated Healthcare Enterprise) , Audit Trails and Node Authentication (ATNA) Profile.	Examples of audit trails include: Versions of installed software, code sets, knowledge bases, backup and recovery resolutions, system date / time changes, archived data storage or restoration, and user EHR System access (internal or external).	1						
S-05	5.004	The system shall store the identity of the user for every instance of: Data entry, Data modification, Exchange of data, Data deleted or inactivated, Report or Query requested or executed.		1						

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S-05	5.015	The system shall be able to detect security-relevant events that it mediates and generate audit records for them. At a minimum the events shall include: start / stop, user login / logout, session timeout, account lockout, client record created / viewed / updated / deleted, scheduling, query, order, node-authentication failure, signature created / validated, PHI export (e.g. print), PHI import, and security administration events. Note: The system is only responsible for auditing security events that it mediates. A mediated event is an event that the system has some active role in allowing or causing to happen or has opportunity to detect. The system is not expected to create audit logs entries for security events that it does not mediate.		1						

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S-05	5.016	The system shall record within each audit record the following information when it is available: (1) date and time of the event; (2) the component of the system (e.g. software component, hardware component) where the event occurred; (3) type of event (including: data description and client identifier when relevant); (4) subject identity (e.g. user identity); and (5) the outcome (success or failure) of the event.		1						Cerner 's auditing solution was designed in response to HIPAA privacy and security provisions, among other considerations, allowing the audit of user actions as patient-identifiable information is accessed. This information includes data identifying the user, the patient, the context of the access, and the actions performed to the patient data, including actions that create, verify, modify, complete, amend\error correct, and print patient information.

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S-05	5.017	The system shall provide authorized System Administrators with the capability to review all audit information from the audit records.	Examples of audit records review include: 1) Reports based on ranges of system date and time that audit records were collected. 2) Logs exported into text format in such a manner as to allow correlation based on time (e.g. UTC synchronization).	1						<p>A GUI Tool is available for system administrators to view information regarding application access. The tool displays information regarding the user, the application, date and time of the attempt, location of the computer and information about the clinical data accessed. The following auditing reports are available:</p> <ul style="list-style-type: none"> • All users with accounts in a particular environment • Users who have not logged on the Cerner Millennium system in last 30/60/90 days • All users by position • All users by application group • All tasks associated to a position • All tasks associated to an application group • All relationships which have been manually created

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<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
S-05	5.018	The system shall prohibit all users read access to the audit records, except those users that have been granted explicit read-access. The system shall protect the stored audit records from unauthorized deletion. The system shall prevent modifications to the audit records.		1						
S-05	5.019	The system shall allow an authorized System Administrator to enable or disable auditing for groups of related events to collect evidence of compliance with implementation-specific policies.	Note: In response to a HIPAA-mandated risk analysis and management, there will be a variety of implementation-specific organizational policies and operational limits.	1						Within Cerner Millennium, your organization can configure what end user operations against patient data and security-relevant events (e.g., user authentication) that you desire to have qualified for audit logging

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S-06	6.001	The system shall be able to generate a backup copy of the application data, security credentials, and log/audit files.		1						You set backups to run automatically in scheduled operations. Cerner Millennium provides scripts for standard backup routines. The Cerner Millennium implementation process blends into the client's back-up strategy whenever possible. Cerner has developed several tools to aid in the backup process. For example, Oracle's Recovery Manager (RMAN) scripting to shorten, to minutes in many cases, the window of time during which the system might be unavailable or impacted in performance.

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S-06	6.002	The system restore functionality shall result in a fully operational and secure state. This state shall include the restoration of the application data, security credentials, and log / audit files to their previous state.		1						
S-06	6.003	The system shall have ability to run a backup concurrently with the operation of the application, if the system claims to be available 24x7 .		1						
S-06	6.004	The system's data and program files shall be capable of being backed up by common off the shelf (COTS) backup tools.		1						

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S-07	7.001	The system shall include documentation to the user stating whether or not there are known issues or conflicts with security services in at least the following service areas: antivirus, intrusion detection, malware eradication, host-based firewall and the resolution of that conflict (e.g. most systems should note that full virus scanning should be done outside of peak usage times and should exclude the databases.).		1						Cerner supports the following PC applications and third party vendor software: <ul style="list-style-type: none"> • Microsoft Windows NT 4.0 Service • Netscape Communicator 4.5 or above • Microsoft Internet Explorer 4.01 and above • Novell GroupWise 5.2 or 5.5 client • Microsoft Office 2000 Professional • Novell Client 32 for Netware • Wall Data Rumba Terminal Emulator • Novell Administrator Software • Windows NT 4.0 User Manager for Domains • Symantec PC Anywhere • Other Software written in Microsoft VB 5.0 or 6.0

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S-07	7.002	The system shall include documentation that covers the expected physical environment necessary for proper secure and reliable operation of the system including: electrical, HVAC, sterilization, and work area, if the system includes hardware.							1	The physical environment is the responsibility of the client.
S-07	7.003	The system shall include documentation that itemizes the services and network protocols / ports that are necessary for proper operation and servicing of the system, including justification of the need for that service and protocol.	Examples of services include: PHP; Web services; etc. Examples of Network protocols / ports include: HL7, HTTP, FTP; etc. This information may be used by the healthcare facility to configure their network defenses (firewalls and routers).	1						
S-07	7.004	The system shall include documentation that describes the steps needed to confirm that the system installation was completed and that the system is operational.		1						
S-07	7.005	The system shall include documentation that describes the patch (hot-fix) handling process the vendor will use for the EHR System, operating system and underlying tools (e.g. a specific web site for notification of new patches, an approved patch list, special instructions for installation, and post-installation test).		1						

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S-07	7.006	The system shall include documentation that explains system error or performance messages to users and administrators, with the actions required.		1						
S-07	7.007	The system shall include documentation of product capacities and the baseline representative configurations assumed for these capacities.	Examples of product capacities include: Number of users; Number of transactions per second; Number of records; Network load; Etc. Examples of baseline representative configurations assumed for these capacities include: Number or type of processors; Server / workstation configuration; Network capacity; Etc.	1						Cerner will work with you to determine the appropriate sizing and hardware requirements.
S-07	7.008	The system shall include documented procedures for product installation, start-up and / or connection.		1						
S-07	7.009	The system shall include documentation of the minimal privileges necessary for each service and protocol necessary to provide EHR functionality and / or serviceability.		1						
S-08	8.001	The software used to install and update the system, independent of the mode or method of conveyance, shall be certified free of malevolent software ("malware"). Vendor may self-certify compliance with this standard through procedures that make use of commercial malware scanning software.		1						

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S-08	8.002	The system shall support key system Performance Metrics.	Example: System access and availability for all authorized users; System Response times.	1						

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S-08	8.006	The system shall be configurable to prevent corruption or loss of data already accepted into the system in the event of a system failure (e.g. integrating with a UPS, etc.).		1						
Infrastructure Totals:				91	0	0	0	0	5	
			96	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	

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F-01	1.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print a unique Master Client Record.	Implies there is only one active Master Client Record at a time.	1						
F-01	1.002	The system shall associate (store and link) key identifier information (e.g., system ID, medical record number) with each Master Client Record.	Examples of Unique Key Identifiers Include: System-generated ID, Provider Organization-assigned Health Record Number, Governmental-assigned client identifiers. Key identifier information must be unique to the client record, but may take any system-defined internal or external form.	1						
F-01	1.003	The system shall be able to store more than one client identifier in each Master Client Record.	Examples of identifiers include: (e.g., Biometrics, SSN, Calif. Medi-Cal CIN, Drivers License, and State ID#). For interoperability, practices need to be able to store a minimum of 3 additional client identifiers. Examples include an ID generated by an Enterprise Master Client Index, a health plan or insurance subscriber ID, regional and/or national client identifiers if / when such become available.	1						Partially supported. Cerner's registration solution does not currently support biometric identifiers.
F-01	1.005	The system shall use key identifying information to identify (look up) the unique Master Client Record.		1						
F-01	1.006	The system shall provide more than one means of identifying (looking up) a client.	Examples of alternative identifiers include: Client date of birth, phone number, medical record number, SSN, CIN, name, and Driver's License number.	1						

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F-01	1.007	The system shall be able to include or exclude client information from reporting functions.	<p>Examples of inclusion and exclusion include:</p> <ul style="list-style-type: none"> - Inclusion by payer relationship, government requirement, income level, case coordinator, etc. - Exclusion by death, transfer, relocation, etc. <p>Being exempt from reporting is not the same as de-identifying a client who will be included in reports.</p> <p>Example of restricted viewing of a client identifier is Social Security Number.</p> <p>Inclusion or exclusion information embedded in the Master Client Record may be designed to affect all or only certain reporting functions.</p>	1						This requirement can be supported with a query written by your organization using our report writer, Discern Explorer.
F-01	1.009	The system shall be able to merge Master Client Records.	<p>Implies client was assigned two or more Master Client Records.</p> <p>Merged data may cause other client data to be merged that is demographic, financial, clinical, etc.</p> <p>Merging doesn't imply destruction of prior information or non-compliance with audit trail requirements.</p>	1						

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F-01	1.011	The system shall be able to integrate client records with information from other databases or EHR computer systems (internal or external).	<p>Examples of Information Integration Include: Community resources listings, Client wait lists, Intake Screenings with call logging, client registrations, client referrals, and funding sources (such as CSI, PATH, SAMHSA, UMDAP).</p> <p>Examples of Call-Logging Data Include: Date of call, staff receiving call, name, telephone number, language requirement, referring party, and call disposition.</p>						1	Cerner will discuss with you the details of this requested functionality to determine if it can be supported.
F-01	1.013	The system shall be able to link additional client classifications to a unique client record.	Examples of Classifications Include: Client care covered by categorical funding and/or grants, High risk status, etc.						1	
F-01	1.014	The system shall be able to prevent multiple Master Client Records for the same client.	Example of prevention techniques includes: Checking databases for duplicate names, home addresses, data of birth, Social Security, etc.	1						
F-01	1.015	The system shall be able to link client identifiers with client demographic data.	Implies linkages that support required data reporting.	1						This requirement can be supported with a query written by your organization using our report writer, Discern Explorer.

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F-02	2.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client demographic data.	<p>Examples of Demographic Information Include: Current Name, Prior name(s), Home or work address; Phone number(s); E-mail addresses; Date of Birth; Contact information for client relatives, friends, or other care advocates; Alternative methods of contact (e.g., alternate addresses, alternate phone numbers, etc.); Etc.</p> <p>It is assumed that all demographic fields necessary to meet legislative and regulatory (i.e., HIPAA), research, and public health requirements will be included.</p> <p>Input may include various types of data including: Free text, multiple choice, and drop-down menu items. See 43.040.</p>	1						Cerner's registration solution supports the ability to delete demographic data values and save demographic data values.
F-02	2.005	The system shall be able to store client demographic information in separate discrete data fields, such that data extraction tools can retrieve these discrete data.		1						
F-02	2.009	The system shall be able to merge separate client demographic data records.		1						
F-02	2.010	The system shall be able to display and review all data in two similar type client demographic records for the same client, identifying the data that is different.	This will support determining the client demographic information that should exist subsequent to merging two records to one.	1						

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F-02	2.011	The system shall be able to require user confirmation prior to merging any client demographic information.		1						
F-02	2.012	The system shall be able to create separate records from client demographic records erroneously merged.		1						
F-02	2.013	The system shall be able to register clients who will receive minimal care.	Implies requiring fewer mandatory fields to be completed.	1						
F-02	2.014	The system shall be able to capture limited pre-registration information when full registration cannot be completed.		1						
F-02	2.015	The system shall be able to store both permanent and temporary client addresses.		1						
F-02	2.017	The system shall be able to navigate between client registration and other screens without loss of registration data already inputted.	Examples of other screens: Scheduling, billing, client identifier lookup, and service / treatment records lookup.	1						Seamless integration is standard between all Cerner Millennium applications. In addition, Cerner Millennium applications can interface to any existing HL-7 compliant system.
F-02	2.019	The system shall allow clients to input data.	Example data includes: demographic, insurance information, family history, social history and prior medical history. Such data entry may occur via Internet Web interfaces, an in-office kiosk, etc..	1						The Cerner kiosk solution provides a secure means for patients to update their own demographic information.

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F-15	15.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client consents and authorizations.	<p>Implies handling of: Hardcopy signatures; Electronic Signatures; Refusal to sign notations; Etc.</p> <p>Includes supporting follow up processes to obtain missing client signatures.</p> <p>Consents and authorizations may be: Sent electronically, Associated with a specific clinical activity, Displayed chronologically, input in a variety of methods (e.g., scanned)</p> <p>Implies timely review capacity and HIPAA compliance.</p> <p>See Practice Management 43.006 and Infrastructure 43.040.</p>	1						
F-15	15.005	The system shall be able to store and display administrative authorizations.	<p>Examples of Administrative Authorizations Include: Privacy notices, etc.</p> <p>Needed for HIPAA. Scanned copy is acceptable for 2007.</p>	1						
F-15a	15a.01	The system shall provide the ability to indicate that a client has completed advanced directive(s).	Important for appropriate use of resources at end-of-life and may just include a Yes/No indication.	1						
F-15a	15a.02	The system shall provide the ability to indicate the type of advanced directives, such as living will, durable power of attorney, or a "Do Not Resuscitate" order.	This may be recorded in non-structured data or as discrete data.	1						

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F-15a	15a.03	The system shall provide the ability to indicate when advanced directives were last reviewed.	This may be recorded in non-structured data or as discrete data.	1						
F-20	20.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print non-medication referral orders with detail adequate for routing.	This could include referrals to sub-specialists, physical therapy, speech therapy, nutritionists, and other nonmedication, nonclinical orders. Adequate Detail Includes, But Is Not Limited To: Date; Client name and identifier; "Refer to" specialist name, address, and telephone number; "Refer to" specialty; Reason for referral; Referring physician name; etc.	1						
F-20	20.002	The system shall be able to record user ID and date/time stamp for all referral-related events.	Necessary for medico-legal purposes. Security	1						
F-20	20.004	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print consultation and referral forms.		1						
F-24	24.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print inter-provider communication.	See Practice Management 43.012 and Infrastructure 43.040.	1						

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F-26	26.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print healthcare service provider demographic information in a directory of healthcare service providers.	<p>Examples of Healthcare Service Providers Include: Health Providers internal or external to the organization responsible for the EHR system.</p> <p>Examples of Demographic Information Include: Provider name, provider location, salaried or contract employment, credentials, language, days and times worked, service specialties, languages spoken, training accomplished, contact information, effective Start / Stop Dates, etc.</p> <p>Examples of Credentialing Include: State licensures (MD, MFCC, LCSW, MFT, LPT, etc.), DEA, and NPI numbers. Credentialing and Certification data shall include Effective and Expiration Dates.</p>	1						
F-26	26.003	The system shall validate, at the point of service entry, that the rendering healthcare service provider is credentialed to provide the service / treatment.	For example, health care service provider is, or is not, credentialed to perform medical medication support service / treatments.	1						Position-level security logic, also known as a role profile, sets permission to access an application or a task within an application, or a task group based on a user's position. Roles are defined for every user in the system.
F-26	26.009	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print healthcare service providers system attributes.	Examples of Healthcare Service Provider System Attributes Include: Relationships to specific fee schedules, specific health plans, specific procedure codes, or groupings of these attributes.						1	

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F-27	27.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information of an Electronic Scheduler.	<p>Examples of Electronic Scheduler functionality include: System wide access; Scheduling of clients, healthcare service providers, interpreters, space, equipment, vehicles, and other resources; Inquiries such as “find first available appointment for Dr. X”; Multi-month advance scheduling for client services and medication management; Entry of recurring appointments, staff comments, and reason for appointment; Overbooking management; User notifications / warnings of potential appointment problems; Assigning resource non-availability; Many to one (providers to client) scheduling, and cancelling, rescheduling or other modification of existing appointments; Modification of appointments to show them as missed, re-scheduled or completed appointments; Interface with charge entry system(s); Interface with Client Appointment Waiting List system(s).</p> <p>Examples of scheduler information include: Client name, client chart number, client date of birth, client gender, client appointment date / time, client telephone number and address, provider name, client co-pay due, service / treatment authorization expiration dates, insurance expiration dates, etc.</p> <p>Scheduler data may be populated either through data entry in the system itself or through an external application interoperating with the system.</p>	1						

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F-27	27.027	The system shall be able to communicate language-appropriate scheduling information to clients.	<p>Examples of scheduling information include: Email, letters, address labels, notices, reminders, phone messages, etc.</p> <p>Examples of reasons for communication include: Missed, canceled, scheduled, or rescheduled appointments; Appointment related follow up communication.</p> <p>Includes automated communication protocols such as: auto-telephone messages and auto e-mail.</p>	1						Cerner's Appointment Reminder Service solution provides communication with patients via phone, email, or SMS text.
F-27	27.038	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information of a Client Appointment Waiting List.	Similar to Electronic Scheduler comments.	1						
F-27	27.041	The system shall be able to display or print information on clients who missed or cancelled appointments.	Displayed / printed information may: Be bound by a user-selected date/time period; Include reasons for cancellations.	1						

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F-27	27.044	The system shall be able to print a charge ticket (super bill) before the appointment or when the client arrives and checks in.							1	However, when a Galvanon kiosk is implemented, patients can use a credit card to make payments and request their outstanding balance. With IQHealth, patients can send a secure message to their physician office requesting an account balance or include their credit card number so the office staff can make a payment on the account.

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F-28	28.001	The system shall be able to generate reports based on existing, or missing, healthcare service, financial, and administrative data.	<p>Implies: Both adhoc and scheduled reporting capability; Ability to Interface to internal and external reporting tools.</p> <p>Reporting Examples include: Reports on multiple clients (i.e., group therapy); Monthly trend reports; Client Diagnosis analysis reports; Healthcare service provider comparison reports: Cost reporting; Usage of disease registries; Usage of standard reports; Usage of complex reporting data queries; Capability to report on all data in the system; Capability to export data to other electronic office formats (e.g., MS Excel, MS Access, etc.); Reporting with multi-layered data sorts; Usage of "wild cards" in report selection parameters; Computation based on system information and report parameters; Analysis related to medications and service / treatments; "Dashboard" reporting; Missing data reports.</p> <p>Examples of Missing Data Reports: A lab test has not been performed or a blood pressure has not been measured in the last year.</p>	1						We have enclosed our ProFit Revenue Cycle Reporting Analytics document for your review.

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F-28	28.004	The system shall allow users to specify report parameter variables (e.g., sort and filter criteria).	<p>Example Variables: 1) Client Demographic and Clinical Data (i.e., all male clients over 50 that are diabetic and have a HbA1c value of over 7.0 or that are on a certain medication). Minimum demographic data are age and gender. 2) Data date ranges. 3) Program Type. 4) Organizational Department. 5) Provider.</p> <p>Examples of Data Date Ranges Include: One or more times per day, weekly on specified day, monthly on first day of month and fiscal period, etc.</p> <p>Includes modifying one or more parameters of a saved report specification.</p>	1						
F-28	28.005	The system shall be able to upload, download, and access report information.	Examples include: Access to print files data output; Upload and download of plain text, MS Excel, Adobe PDF, and XML file formats.	1						Uploads must be in ASCII format. Extracts can be put into a client-defined format.
F-28	28.007	The system shall be able to save report parameters for generating subsequent reports.		1						

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<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
F-28	28.009	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print a variety of outcome measurement instruments.	Includes using locally-defined and third-party licensed scoring protocols to summarize outcome instrument data.						1	PowerInsight Enterprise Data Warehouse enables your healthcare executives to measure and manage clinical, financial, and service level outcomes. Our solution provides a variety of reports to give management insight into the effectiveness and efficiency of health management across member encounters within your health system. Specifically, our solution captures key factors impacting patient outcomes. Your organization can create reports of clinical guideline compliance as well as transfer and readmission rates, sorted across various dimensions. All data from the chart is not captured.
F-28	28.011	The system shall allow on-line clinical review of outcome score trends over time.	This capacity is intended to support clinical decisions.	1						

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F-28	28.013	The system shall be able to report in various formats.	Includes reporting to different media, (E.g., Screen displays, Printed paper, and electronic files) Examples of formats include: ASCII , XLS, CSV, PDF, MDB, TXT, DIF, XML, etc.	1						
F-28	28.014	The system shall allow report specifications to be copied, edited and added to the reports menu with a new report name.	Storage location of report specifications and created reports should be able to be configured by the individual facility.	1						PowerInsight Enterprise Data Warehouse provides your facility the flexibility for your users to create their own files and favorite reports. These can then be organized as needed by your users.
F-28	28.016	The system shall support the collection, compilation, reporting and analysis of all mandated outcomes.		1						Many of the necessary data elements for your reporting and analysis of all mandated outcomes may be captured by Cerner's Data Warehouse. We will need to know the specific data elements for which you require support in order to propose the appropriate Cerner solution.

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F-28	28.017	The system shall support reporting and data analysis of the County's Quality Assurance Programs.	Quality Assurance: The development and production of reports based on Payor- and County-identified performance and outcome measures for access, assessment, service/care planning, service / treatment delivery, etc. Also aids random chart sampling and review processes.	1						Our system does not have a quality assurance workflow application. However, through PowerInsight Enterprise Data Warehouse, we can perform analysis and trending that may be of interest to quality assurance leadership. Our solution encompasses clinical, financial, and service level outcomes. It produces "definable quality" and analyzes how effective a quality outcome was produced. To support random chart sampling, PowerInsight Enterprise Data Warehouse supports the ability to produce lists and charts, allowing you to choose the data you want to display.

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F-28	28.018	The system shall support reporting and data analysis of the County's Quality Improvement Programs.	Quality Improvement: The development and production of reports that track and trend quality measures over time and can support the identification of variation that is material and statistically significant.	1						Our system does not have a quality management workflow application. However, through PowerInsight Enterprise Data Warehouse, we can perform analysis and trending that may be of interest to quality management leadership. In addition, Regulatory Reporting: NHQM (AMI, SCIP, HF and PN) provides the reporting structure required to support the content and data collection for the specified Joint Commission/CMS NHQM measures. Our solution provides the NHQM core measures data for AMI, HF, PN and SCIP currently. Additional measures supporting CAC and outpatient measures are in development.

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F-28	28.019	The system shall support reporting and data analysis of the County's Utilization Review Programs.	Utilization Review: The development and production of reports that track utilization throughout the county and identify specific clients, clinicians, service / treatments, and/or programs that are above or below user-designated trigger thresholds.	1						PowerInsight Enterprise Data Warehouse supports the ability to measure, analyze, and report upon service utilization analysis, physician utilization activity, and patient utilization analysis. Our solution does not support specific utilization management. For Utilization Review, PowerInsight Enterprise Data Warehouse supplies data that helps your health care organization improve their outcomes by providing actionable and timely information. This information is updated daily allowing you to have the most recent information available. Our solution assists in improvement of patient care patterns by supporting the analysis of encounters and episodes of care that cross multiple service lines and facilities.

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F-28	28.022	The system shall be able to measure system performance impacts due to the execution of reports simultaneous to other system operations.		1						PowerInsight Enterprise Data Warehouse is designed to provide fast, interactive analysis without an impact on your online transactional processing system (OLTP). Our solution resides outside of the Cerner Millennium database. The data warehouse is hosted on its own hardware and its own database instance, thereby reducing reporting and analysis impact to the OLTP.
F-28	28.024	The system shall be able to interface with SQL-compliant third-party report writer applications.	Examples of Third-Party Report Writers Include: Crystal Reports, Microsoft Access, R&R Report Writer, etc.	1						
F-28	28.025	The system shall support a letter-writing/mail merge function.	Examples of merge includes: Microsoft Word integrated with the system to produce letters to clients, clinicians and other parties.		1					Planned for Revenue Cycle Ambulatory.
F-28	28.026	The system shall support letter templates.	Examples of Support Include: Automated generation of a referral letter; generation of a follow-up client letter when an appointment is recorded as a missed appointment.	1						
F-28	28.028	The system shall support the export of production database data to a reporting server or data store.	Implies support for maintaining integrity of production data and improving system performance.	1						Cerner supports export of data from its data base.

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F-28	28.031	The system shall be able to display and print database documentation.	Examples of Database Documentation Include: A complete data dictionary and Entity Relationship Diagram of all of the tables, table relationships, fields, and field attributes.	1						
F-28	28.032	The system shall support drill-down reporting to examine the underlying data behind figures on report displays.	Common to "Dashboard" reporting.	1						For analytical purposes, the ability to drill down is a strong point for PowerInsight Enterprise Data Warehouse. You can quickly select items you are interested in looking at and drill into additional detail. Our solution does not limit you to a single drill path. Details in many dimensions can be added to a report rapidly and inquired upon down to the transaction level.
F-28	28.034	The system shall provide predefined views of data sets that merge data from multiple tables into logical reporting groupings.	Examples of Predefined Views Include: Predefined by Clients; Predefined by healthcare service providers; Predefined by administrative staff; Predefined views including service / treatments, service / treatment authorizations; Etc. Predefined views assist nontechnical users in creating new standard, management, and ad hoc reports.	1						

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F-28	28.035	The system shall be able to report by groupings of client demographics data.	Examples of grouping include: User-defined population cohorts, geographic clusters of ZIP codes, groupings of client eligibilities, etc.	1						This requirement can be supported with a query written by your organization using our report writer, Discern Explorer.
F-28	28.036	The system shall support bidirectional transfer of data between business associates.	Examples of business associates include: State and County or County to County	1						We support interfaces using HL7 and TCP/IP
F-28	28.037	The system shall be able to report data through national healthcare electronic transaction standards.	Examples of national standards include: HL-7 and ASC X12N transactions; support the translation of data sets based on predefined translation code tables; support the development of error-checking routines, flagging via error reports, and the ability to readily resolve nonmatching data.	1						We support HL7 and X.12N. Reference data would use csv files. All data is validated before being posted to the Cerner Millennium database.
F-28	28.038	The system shall be adaptable to specification changes from payors, and other business associates.		1						Changes would have to be reviewed and an Arrangement Letter would be drafted.
F-28	28.039	The system shall support client satisfaction surveys reporting.	Implies scheduled and on-demand surveys.						1	
F-30	30.016	The system shall be able to notify user immediately of data entry validation errors.	Examples of Data Entry Validation Include: Authorized practitioner scope of practice, service site, department, service provider, etc.	1						

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F-30	30.021	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client service / treatments, including those that are group based.	<p>Implies participants in a group may be coordinated by several different teams within the same agency; groups can easily be created or modified.</p> <p>Implies when service / treatments are entered for a group, all group members are to be displayed for rapid data entry.</p> <p>Implies data entry retrieval by date, client identifier, service / treatment type, provider identifier, diagnosis, referred provider, client care funding, and client financial liability, etc.</p>	1						A variety of patient lists can be created and can include personal, location, lifetime relationships, visit relationships, care team, medical service, provider groups. scheduled based and query based. Query based patient lists returns patients based on a custom Discern Explorer query written by your organization. The patient list is a view that can be displayed in our electronic medical record's organizer. All lists provide access to selected patient charts.
F-30	30.022	The system shall allow for multiple healthcare service providers in a group to have different billing and documentation times per client service.			1					Further clarification regarding your requirement for documentation times per client service would be helpful. We support the ability to have different billing cycles. Planned for Revenue Cycle Ambulatory.

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F-31	31.002	The system shall be able to select, or offer choice, of an appropriate billing code and billing fee based on data input for, or supporting, a client service / treatment.	Examples of choice include:: Selection of a CPT Evaluation and Management code based on provider documentation. May be accomplished via a link to another application.	1						With Batch Charge Entry you can select a specific charge and CPT-4, modifier, or diagnosis code from a search option to associate it.
F-31	31.004	The system shall provide the ability to interface the most current procedure code with the current service/Care Plan.		1						New procedures can be interfaced after being built into the system.
F-31	31.005	The system shall support financial and administrative rules that allow posting charges for more than one day for one client on one screen.			1					Planned for Revenue Cycle Ambulatory.
F-31	31.009	The system shall support financial and administrative rules that allow exporting charges to a current or future practice management system.		1						This is currently supported with our standard charge file to a foreign billing system.

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F-31	31.010	The system shall support financial and administrative rules that ensure actual payor charges match the clinical charting.		1						Supported by Cerner's PowerChart CDR and PowerNote. We provide a unique, patented structured clinical documentation solution that allows clinicians to review the patient record, document, and order from one screen and uses problem-specific templates or encounter pathways. A series of options or smart pick lists present symptom-, guideline-relevant documentation and plan elements. The care designs present recommended options, but allow the clinician to select the appropriate actions by point-and-click with a mouse or pen. A textual clinical note is created, accurately and instantly, as a by-product of care.

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F-31	31.015	The system shall have the ability to provide a list of financial and administrative codes.	For example, ICD-9 CM, ICD-10 CM, and CPT-4 codes.		1					You can add bill codes (CPT, ICD9, CPT Modifiers) to the charge in Charge Viewer after the charge has generated. If the code is always the same, it can be pre-built as reference data and always associated to the charge. you can also select from these codes during the charge entry process. ICD-10 are not currently supported in the U.S but will be once the final Federal rule is published with dates.
F-32	32.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print eligibility data obtained from a client's third party payor.	Implies participants in a group may be coordinated by several different teams within the same agency; groups can easily be created or modified. Implies when service / treatments are entered for a group, all group members are to be displayed for rapid data entry. Implies data entry retrieval by date, client identifier, service / treatment type, provider identifier, diagnosis, referred provider, client care funding, and client financial liability, etc.	1						

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F-32	32.004	The system shall be able to process retroactive health plan eligibility.	Implies that a new eligibility record is added to the system for each client monthly Medi-Cal eligibility, including all retroactive additions to Medi-Cal.	1						
F-32	32.005	The system shall be able to comply with electronic transmission of HIPAA-Compliant Eligibility Determination, Enrollment and Disenrollment formats.	Implies usage for benefit eligibility determination in Medi-Cal, Medicare, Insurance, and other third party payor systems.	1						Cerner adheres to the standard x12 structure for eligibility determination. Further discussion of enrollment/disenrollment is requested in order to provide an accurate response.
F-32	32.007	The system shall support Medi-Cal eligibility evaluation of registered clients..	Examples of Evaluation Support Include: For clients with no Third-Party coverage reporting their full names, identification information, and all encounters / charges within a user-specified date range; Obtaining financial screening information necessary for determining Medi-Cal eligibility; etc. Evaluation may be ad hoc or scheduled daily, weekly, monthly, etc.						1	
F-32	32.009	The system shall support the manual on-line review and update of insurance records, as necessary.	Examples of Special Handling Conditions Include: Partial eligibility match requiring investigation, Clearing Medi-Cal Share-of-Cost responsibility, CMSP eligibility, other State aid codes, Medicare, private insurance, and Medi-Cal clients with a different responsible county.	1						

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F-32	32.015	The system shall integrate Medi-Cal eligibility assessments processes with eligibility referral systems.		1						Cerner assumes this requirement to refer to the functionality of the 278 transaction provided with the purchase and implementation of Cerner's registration and benefits solutions.
F-32	32.016	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print data required for the support of various pharmaceutical company indigent client, "Patient Assistance Programs (PAP)".	Patient Assistance Programs support indigent healthcare.						1	
F-32	32.017	The system shall be able to generate medication-specific "Patient Assistance Programs (PAP)" applications forms to request medications at no cost from manufacturers.	Implies different application forms for multiple Patient Assistance Programs						1	
F-32	32.019	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print "Patient Assistance Programs (PAP)" forms and the status of related pending applications.							1	
F-33	33.001	The system shall be able to identify by name all healthcare service providers associated with a specific client service / treatment.	A healthcare service provider is defined as anyone delivering clinical care such as physicians, PAs, CNPs and nurses; the provider is the person who completes the note.	1						

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F-33	33.002	The system shall be able to specify the role of each provider associated with a patient, such as encounter provider, primary care provider, attending, resident, or consultant.	This is simply meant as a means to define the provider role. Display of that data is not addressed.	1						
F-33	33.003	The system shall be able to display and print the primary or principal provider responsible for the care of a client within a care setting.		1						
F-33	33.004	The system shall be able to create a list of all clients who have had a service / treatment with a given healthcare service provider.		1						Supported with a query written by your organization using our report writer, Discern Explorer.
F-40	40.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all mandated reporting data.	Examples of Mandated Reporting Data Areas Include: California CSI, DCR, and OSHPD reporting.	1						Many of the necessary data elements for your mandated reporting may be captured by Cerner's Data Warehouse. We will need to know the specific data elements for which you require support in order to propose the appropriate Cerner solution.
F-40	40.002	The system shall be able to import and integrate external mandated reporting data.	Examples of External Mandated Reporting Data Areas Include: DCR and Cost-Reporting. (XML Schema Definition files, etc.)	1						Millennium Objects is required to send out XML format.
F-40	40.004	The system shall be able to produce reports based on absence of mandated data elements.		1						

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F-40	40.006	The system shall be able to generate error or suspension reports prior to submission of a mandated report.		1						
F-40	40.007	The system shall be able to specify the output file format for mandated reporting.	Examples of file formats include: XML, CSV, etc.	1						
F-40	40.008	The system shall be able to produce all mandated reports.	Examples of mandated reports include: DMH EOY Cost Reporting, CSI & OSHPD, MHSA, PATH, and SAMHSA Reporting.	1						

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F-40	40.009	The system shall be able to translate healthcare service provider coding into required reporting formats.	Examples of Data Coding Include: Ethnicity codes, Gender, etc. Implies automated and manual translation capability.	1						We offer an integrated, automated E&M coding assistant that can be used to calculate the level of visit and determine the appropriate E&M code. When used with our structured clinical documentation solution, the E&M coding assistant analyzes documentation to automatically calculate the level of history and exam supported by the documentation. We also provide an E&M coding assistant which requires manual entry. This enables clinicians to determine the appropriate E&M code for patient encounters based on current Center for Medicare and Medicaid Services (formerly HCFA) guidelines. The selected code is then saved in the patient record and passed to the master charge summary for billing.

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F-40	40.011	The system shall support validation of mandated reporting data.	Examples of validation include: Verifying date of service / treatment consistent with provider employment or contract period; Treatment / Service meets any authorization requirements; Reporting adheres to all mandated reporting rules; Target population for reporting matches system data attributes, Etc.	1						
F-40	40.012	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print healthcare service Treatment Authorization Requests (TARs).	Examples include both Inpatient and Outpatient TARs.	1						
F-40	40.013	The system shall be able to input modify, inactivate, delete, update, display, copy, and print client care episodic data.	Examples include: Inpatient and Outpatient episodes data; Related Utilization Review notes; User-defined checklists; Daily census and bed statistics; etc.						1	Partially Supported. Daily Census and Bed Statistics are supported with Cerner's registration solution. Patient data stored within the Cerner Millennium database is not deleted. Users at your organization have immediate access to the entire patient record, including information from current and past visits. Related Utilization Review notes is not supported.

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F-41	41.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print Accounts Payable information.	Examples of Accounts Payable information include: Receiving HIPAA 837 and 997 transactions; Receiving hardcopy health claims information;		1					Planned for Revenue Cycle Ambulatory. Once a transaction (charge, payment, or adjustment) is posted to the A/R we do not allow it to be deleted. You can modify it, update it, print the information but cannot delete it.

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F-41	41.002	The system shall be able to adjudicate health claims payment-related requests.	<p>Examples of Health Claims Payment-Related Requests Include: Receiving HIPAA 837 and 997 transactions; Receiving hardcopy health claims.</p> <p>Examples of Adjudication Basis Include: Payee eligibility; Client eligibility; Insurance plan priority for sequential payors; Date of service; Service or provider authorization; Covered diagnosis; Fee schedules; etc.</p> <p>Examples of Requirements Include: Reimbursement by case rate, fee for service, capitation, fixed fee payments; etc.</p> <p>Examples of Adjudication Process Include: Printing of hardcopy Explanation of Balance (EOB) information when appropriate; User-defined letters to issue to health claim providers; etc.</p>		1					<p>Partially supported by Revenue Cycle Ambulatory. We do not process claims for adjudication. We support posting of electronic remittance advices as well as the actual contractual received on the ANSI x.12 835. Payments, denials and adjustments are all entered in the same posting "conversation" –whether manual or electronic—and at the level of detail specified in the transmission. Cerner produces a 4010 HIPAA compliant 837 transaction. We can interface to any clearinghouse that can accept a 4010 837 format. In addition, we support the X12 997 functional acknowledgement transactions that are provided directly from payors.</p>

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F-41	41.003	The system shall be able to adjudicate health claims to a per claim line basis.	Implies automated and manual adjudication capability.				1			With custom scripting we support "Net Billing".
F-41	41.005	The system shall transmit HIPAA-compliant transactions in response to receipt of incoming HIPAA-compliant transactions.	Examples of HIPAA-compliant transactions include: ASC X12N 835 - Healthcare Payment and Remittance Advices		1					We currently support the 837I and 837P, the 835, and acceptance of 997s. Planned for Revenue Cycle Ambulatory
F-41	41.006	The system shall be able to forward External Provider ASC X12N 837 Health Claims to claim payors.	Examples of claim payors include: Short-Doyle Medi-Cal, Medicare, Insurance, and other providers (such as other Counties).		1					Planned for Revenue Cycle Ambulatory
F-41	41.007	The system shall be able to pend claims for review and subsequent approval or denial.			1					Planned for Revenue Cycle Ambulatory
F-41	41.008	The system shall be able to integrate with an accounts payable system that supports EHR related claiming.		1						We have a standard Accounts Payable interface and support the ability to submit refunds.

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<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
F-41	41.010	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print Accounts Payable (A/P) claim payments, denials, and adjustment transactions.	Examples of Adjustments Include: Claim A/P entries that are to be reversed; Credit balances cleared; etc. Implies that adjustments shall also be included in related Remittance Advices.		1					Will be partially supported by Revenue Cycle Ambulatory. Credit balances can be brought to users' workqueues for review and resolution. Our Revenue Cycle Ambulatory solution then requests a refund, which is interfaced to the Accounts Payable system. Once a transaction (charge, payment, or adjustment) is posted to the A/R we do not allow it to be deleted. You can modify it, update it, print the information but cannot delete it.

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F-41	41.011	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print A/P audit trail transactions.	Implies ability of an audit trail for all A/P transactions; integration with Audit Trail business rules.	1						Further clarification of your requirement for Audit Trail business rules would be helpful. We provide a view of Accounts Payable refunds and the related transactions. Once a transaction (charge, payment, or adjustment) is posted to the A/R we do not allow it to be deleted. You can modify it, update it, print the information but cannot delete it.
F-41	41.012	The system shall be able to input, modify, inactivate, delete, update, copy, and print payment and denial information from providers related to coordination of benefits.			1					Planned for Revenue Cycle Ambulatory. Once a transaction (charge, payment, or adjustment) is posted to the A/R we do not allow it to be deleted. You can modify it, update it, print the information but cannot delete it.

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F-41	41.014	The system shall be able to limit EHR-related claims by claim payment limits.	Examples of Limits Include: Total contract amount; Fee Schedule Maximums; Contract term; etc.						1	Our negative response is based on the interpretation you are asking for the system to apply some kind of claim balance limit based on what is allowed by the payor. We do not support that. If this is not the correct interpretation of your requirement, we welcome further discussion.
F-41	41.015	The system shall be able to display and print claim information by various criteria.	Examples of Criteria Include: Vendor identification, Payor source, Payment amount, Denial or approved status, Client identification, etc.		1					Planned for Revenue Cycle Ambulatory.
F-41	41.016	The system shall be able to generate required Internal Revenue Service (IRS) Form 1099 documents each calendar year end.							1	

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F-41	41.018	The system shall be able to reimburse payors due to A/R adjustments.	Reimbursements may be due to overcharges, overpayments, incorrect service / treatment entry, incorrect software application routines, therapeutic adjustments, etc.		1					Planned for Revenue Cycle Ambulatory. Credit balances can be brought to users' workqueues for review and resolution. Our Revenue Cycle Ambulatory solution then requests a refund, which is interfaced to the Accounts Payable system.

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F-42	42.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print Accounts Receivable (A/R) transactions information.	<p>Examples of A/R transactions input methods include: Electronic ASC X12N 835 - Payment and Remittance Advice data; Hardcopy A/R data; Etc.</p> <p>Example of A/R Transactions Include: Charge, payments, and adjustments.</p> <p>Examples of Transactions Information Include: Payor source; Payment reason; Contractual allowance amount; Sliding-scale discount amount; Incorrect fee adjustment; Therapeutic adjustment (authorized by County Mental Health Director); Bad debt write-offs; Client identification; Account identification; Name of the person who posted the transaction; Posting date; Transaction type; Transaction amount; Updates to account balances; etc.</p> <p>Examples of Adjustments Reasons Include: Service / treatment costs adjustments due to capitated or grant-in-aid funding streams; Medicare adjustments due to "accepting assignment"; Retroactive health plan enrollment (e.g., Medi-Cal, Medicare, and private insurance); client sliding-fee scale liability changes (e.g., UMDAP); etc.</p> <p>Examples of Transaction Processing Include: Automated, manual, real-time, batched, scheduled and adhoc posting; posting that minimizes repetitive keystrokes; Payments posted though there are no related charges; Payments / Charge matching suspended though payments posted; Running totals that allow verification that individual payment detail</p>		1					Once a transaction (charge, payment, or adjustment) is posted to the A/R we do not allow it to be deleted. You can modify it, update it, print the information but cannot delete it. Planned for Revenue Cycle Ambulatory

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			<p>oldest balance or to individual open items; Linking transactions to client accounts and to specific charges/invoices. Posting of multiple client transactions by same payor; Notification of discrepancies in transaction posting, Linking transaction a payment or adjustments category (type); A/R linkage to A/P payments for required payor reimbursement; Adjustments to client account balances (including UMDAP); etc.</p> <p>Input implies integration of A/R data with related EHR</p>							
F-42	42.002	The system shall be able to transmit and receive A/R health claims information.	<p>Examples of A/R information include: HIPAA 837 and 997 transactions; "Passing through" claims data to another healthcare services provider; ASC X12N 835 transactions; Other uploads and downloads such as client UMDAP liability; Etc.</p>		1					<p>Partially supported. We do not currently provide standard functionality to support client UMDAP liability. We currently support the 837I and 837P, the 835, and acceptance of 997s. Planned for Revenue Cycle Ambulatory.</p>

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F-42	42.003	The system shall provide accounts receivable support for cost reporting requirements.	<p>Examples of Accounts Receivable Support Include: Translations to mode of service and service function codes; Unit of service calculations based on minutes; Limitations per Scheduled Maximum Allowance (SMA); Legal Entity & Provider Codes; Revenue classifications such as Healthy Families, AB3632, EPSDT, Medi-Cal, Medicare, Medi-Cal / Medicare, Indigent, etc.</p> <p>Examples of Required Reporting: DMH EOY Cost Reporting, CSI & OSHPD, MHSA, PATH, and SAMHSA Reporting.</p>				1			We anticipate we can support this with custom extracts. We welcome the opportunity to discuss the data elements required for your specific reporting requirements.
F-42	42.005	The system shall be able resubmit or to correct, then resubmit Health Claims.	This requirement allows rebilling payors for lost claims, etc., as well as void, replacement, correction and resubmission of claims previously denied by the health claim payor.		1					Planned for Revenue Cycle Ambulatory
F-42	42.008	The system shall be able to print paper-based A/R claims information.	<p>Examples of Paper-based A/R Claims Include: HCFA-1500, UB-92 and user-defined formats; ad hoc or scheduled printing.</p> <p>This includes claims which are forwarded electronically to the County from contract providers for submission to payors and the corresponding forwarding of remittance advices back to the contract providers.</p>	1						We currently support HCFA-1500, UB-92, UB-04, and CMS 1500 claims.

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F-42	42.009	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all required A/R business rules.	<p>Examples of Areas of A/R Rules Include: Third-Party Payor rules (e.g., Medicare, Medi-Cal, Insurance); Service / treatment authorization; Benefit limits; Deductibles; Co-pays; Service / treatment coverage; Required payment write-offs; Documentation requirements complete prior to billing; Reimbursement methods (e.g., Fee-for-service, case rates, per diem, capitation, and the bundling and unbundling of service / treatment codes by payor); Fee schedule rules (e.g., County Board of Service approved fees; UMDAP fees, CalWorks, Healthy Family, Federally Qualified Health Center (FQHC), and Refugee Population programs fee rules; Multiple payor fee prioritization, fee effective start/stop dates; Fee type (e.g., fees per program, payor, contractual agreements; Ensuring that revenue and A/R balances do not overstate outstanding amounts by reporting balances for multiple payors simultaneously; Sending follow-up reports to staff based on transaction notes information; Most recent assigned client diagnosis becomes the default global client diagnosis used for current A/R purposes; Data validation; Automatic translation of health care provider coding into required accounts receivable related claiming or reporting formats; etc.</p> <p>Implies fee schedules are interfaced with other EHR systems.</p> <p>Examples of Medi-Cal billing Rules Include: Preventing billing for clients that have no known Medi-Cal eligibility during the month of service / treatment, Clients who have not met Medi-Cal Share of Cost liability; Healthcare provider documentation that is incomplete; Duplicate claiming; Clients who reside in an Institute for the Mentally Diseased (IMD), Board and Care costs on a Psychiatric Health Facility, etc.</p>						1	It will be necessary to meet with you and obtain a fully detailed list of your requirements for each one of your business rules. Cerner's charge master permits an unlimited number of fee-for-service schedules. Each charge item can have an unlimited number of prices and price schedules. Tiering logic selects the correct price based upon elements associated with the charge including patient type, financial class, and insurance plan, as well as selecting the appropriate CPT code schedule (based upon user-defined parameters). Case rates, per diem, and capitation requires the licensing of a contract management system.

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F-42	42.010	The system shall be able to enforce all required A/R business rules.	<p>Implies system has capability for automatic and manual calculation of all client benefit-plan(s) co-pays and deductibles.</p> <p>Examples of payor sources with billing rules include: Medicare, Medi-Cal, Insurance, California State funding programs (E.g., CalWorks, SAMHSA, PATH, MHSA FSP, AB3632/26.5 and MIOCR funding sources; California Specific AB3632 (where payments are limited to those service / treatments authorized in a youth's Individualized Education Program (IEP) authorization);</p> <p>Examples of required billing rules may be found in a variety of sources such as: CA DMH Information Notices; CA DMH Letters; CA DMH HIPAA 837 Companion Guide; CA DMH CSI manuals; Federal OMB Circulars; and Federal Medicare Guidelines.</p>				1			With our standard functionality, we support all the HIPAA-compliant billing rules. However, every payor has their own custom billing rules, and Cerner can support these with custom scripting. We welcome the opportunity to discuss your custom scripting requirements.
F-42	42.020	The system shall be able to display and print payor billing invoices.	<p>Examples of Client Billing Invoice Content Include: Appropriate UMDAP-related fees; Medi-Cal Share-of-Cost charges; One bill has charges for all service / treatments provided within the billing invoice date range.</p> <p>Invoice printing may be ad hoc and scheduled.</p>						1	

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F-42	42.027	The system shall support client liability collection processes.	<p>Implies automated and manual collections support processes.</p> <p>Examples of Collection Support Include: Documentation of attempts at obtaining client outstanding liability and support for adherence to provider A/R debt transfer protocols; Support for related tickler systems; Transfer of client account to collections; Reporting on A/R related contract dates, collections notes, and grouping of payors for collections purposes.</p>		1					Planned for Revenue Cycle Ambulatory
F-42	42.029	The system shall be able to display and print billing statements.	<p>Implies adhoc and scheduled billing statements,Creation of user-defined billing statement formats.</p>		1					Will be partially supported by Revenue Cycle Ambulatory. User-defined billing statement formats will be supported by third party print vendors.
F-42	42.030	The system shall be able to prevent printing of client billing statements and client invoices, and note the reason.	<p>Implies client bills will have all applicable charges, payments and adjustments.</p> <p>Examples of Reasons to Prevent Billing Are: Management billing overrides; AB3632 eligibility; Clients who have Medi-Cal coverage shall not receive statements; Entire client billing processes suspended; Awaiting a response from a third-party payor; Research on client accounts underway, etc.</p>	1						This is supported with manual holds or custom hold scripts.
F-42	42.031	The system shall be able to redirect client billing statements.	<p>Examples are: Redirection of client statement to the client/guarantor, the client's conservator, or both.</p>	1						We send the statement to whomever is identified as the guarantor. This can be updated as needed.

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F-42	42.032	The system shall be able to place messages in client billing statements.	Examples are: Culturally appropriate billing warnings, payment thank-you messages, and healthcare service provider messages.		1					Planned for Revenue Cycle Ambulatory
F-42	42.034	The system shall be able to display and print an audit trail of client billing invoices and statements.			1					Planned for Revenue Cycle Ambulatory
F-42	42.038	The system shall support estimated costing of all provider service / treatments rendered (direct and indirect service / treatments).	The estimated cost of a direct service / treatment for a client is typically determined as stated in Standard fee setting requirement above. Estimated cost of either direct or indirect service / treatment is intended to assist the provider in managing or reporting on estimated year end service / treatment or program costs. Usage of this capability will be provider specific.						1	
F-42	42.039	The system shall be able to compare service / treatment fees to the related Statewide Maximum Allowance (SMA) set by the CA DMH.	The SMA is a SD/MC rate cap which is updated annually by CA DMH.	1						
F-42	42.044	The system shall be able to issue sequentially numbered payment receipts.			1					Planned for Revenue Cycle Ambulatory

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F-42	42.048	The system shall support controls for reconciling A/R postings.	Examples of Support Include: Ad hoc or scheduled printing of receipts information regarding Posting staff, service / treatment, provider organization, date range, site, service / treatment charges, total deposit amount, bank and check numbers, etc.	1						We support standard cash posting reports that can be run on demand to view batches posted by user and transactions. You can also view receipts related to their transaction and print on demand.
F-42	42.051	The system shall support that outstanding charges remain as an open receivable until paid or adjusted.			1					Planned for Revenue Cycle Ambulatory
F-42	42.052	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print A/R audit trail transactions.	Implies ability of an audit trail for all A/R transactions; integration with Audit Trail business rules.	1						Once a transaction (charge, payment, or adjustment) is posted to the A/R we do not allow it to be deleted. You can modify it, update it, print the information but cannot delete it.
F-42	42.055	The system shall display and report Aged A/R data.	Examples of Reporting Include: Ad hoc and scheduled displays or reports; reports of claims paid, claims denied, claims in suspense, claims re-billed; Detailed aged accounts receivables by user-defined sorts and subtotal criteria including payor, provider, client, program, location; Reporting by selected date ranges, etc.	1						We have enclosed our ProFit Revenue Cycle Reporting Analytics document for your review.

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F-42	42.057	The system shall be able to display and report A/R transaction history information.	<p>Examples of Account Transaction History Include: Charges, Payments, Guarantor information, Account status codes, Account balances, Assignment acceptance, Effective Start/Stop Dates, Transaction adjustments, Provider and support staff notes attached to A/R transactions, etc.</p> <p>Displays and reports may be configured for accrual versus cash basis, selected payors and date ranges.</p> <p>Examples of Displays and Reports Management Include: Filtering to show the same information for a single payor (including client responsibility), A/R status displays on various system screens such as those for client registration or scheduling.</p> <p>Examples of Reports Include: Revenue analysis reports by provider, service / treatment type, funding source, program, etc; Claim status reports; Insurance or Provider comparison reports; Credit Balance Reports; Bad debt reconciliation reports; Client refund reports; Outstanding Balance reports summarizing inactiivty; Overdue payment report; Payor Denial reports, Non-Sufficient Fund payment reports; Capitated Funded Clients listing; and Daily transaction log report.</p> <p>Daily transaction logs may be organized by patient name in alphabetical order or by account number, and include: Date of service/treatment, posting date, provider's name, transaction description, transaction type, and transaction amount.</p>		1					Partially supported by Revenue Cycle Ambulatory. We support standard accounting such as accrual, not cash basis. We have provided our ProFit Revenue Cycle Reporting Analytics document for your review.

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F-42	42.058	The system shall be able to attach notes to A/R transactions.	Examples of A/R notes include: Notes regarding collection calls to clients; Client verbal consents regarding account payments; Follow-up notes to provider staff; etc.	1						
F-42	42.089	The system shall be able to provide A/R notifications and messages to users.	Examples of A/R Notifications and Messages Include: Prompting user with client payor-specific questions, Displaying comments or flags indicating client-related information, Billing information to relate to client during client appointment, etc.	1						Partially supported. We do not support prompting the user with client payor-specific questions.
F-42	42.099	The system shall support single source billing.		1						
F-42	42.102	The system shall support client directed billing rules.	Examples of Support Include: Billing or not billing for AB3632-related children services, Monthly payments on annual UMDAP liability, etc.				1			This would be supported with custom rules. However, we will provide rule tools for your organization to use.
F-42	42.107	The system shall support compliance with Generally Accepted Accounting Principles (GAAP).		1						

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F-42	42.113	The system shall be able to prevent entering non-valid A/R data.	Examples of Prevention Include: Preventing posting A/R data to the wrong open receivable, provider, service, client, etc.	1						When the transaction posting codes are set up correctly, they will only post to the account they are allowed to, based on build. When posting electronic transactions, for example an 835, we do match on several things like claim number and date of service to be sure we are posting to the correct account. We cannot prevent end users' mistakes. If they enter the wrong claim number or patient number when posting transactions, there is nothing to tell us that it is wrong.

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F-42	42.121	The system shall be able to follow mail specifications of the US Postal Service.	Examples of mail specifications include: Printing ZIP+4 and bar coding requirements.	1						Further clarification regarding the applicability of your requirement to patient accounting would be helpful. We do support printing information as it is entered in the system. Thus, for claims or statements we print the data as it was entered in the system.
F-42	42.124	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information regarding accounts in collections.			1					Planned for Revenue Cycle Ambulatory. We do not "delete" any data. We support modifications to data as well as sending data to a history view, but we do not "delete" anything.

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F-42	42.125	The system shall generate collection letters.	Implies ability to create / use collection letter templates.		1					We support generation of patient inquiry letters that are predefined. The content for patient inquiry letters will be defined by your organization. Once these letters are loaded, they are available to generate at the encounter level in our billing and accounts receivable solution. The end user will right click on the encounter, select inquiry letters, and a window opens up and your Microsoft Word document icons are viewable. The user selects the letter desired and it generates pulling in identifying information from that encounter, such as patient name, financial number, and account number. The end user can save the Patient Inquiry Letter off on a network drive. Planned for Revenue Cycle Ambulatory.

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F-42	42.142	The system shall be able to inform A/R staff of client data changes made outside A/R scope of practice but which affect A/R processes.	Examples of Changes Include: Client address changes; Name changes, etc. System rules may allow automatic updates of A/R system data.	1						This is currently supported when using Cerner's registration solution.
F-42	42.147	The system shall support double entry accounting.		1						
F-42	42.154	The system shall support general ledger journal entries.	Examples of support include: Detailing revenue, adjustments, payments, bad debts, and refunds by account number (segmented by site and department).		1					Planned for Revenue Cycle Ambulatory. We will support transfer of A/R information to a foreign general ledger system through a flat file interface.
F-43	43.001	The system shall support accounting for all daily staff work time.	Examples of Staff Time Include: Client-related and nonclient-related activities.	1						Staff Scheduling supports the ability to track both clinical time and non clinical time. Further clarification of your requirement would be helpful. We will support productivity reporting based on action codes assigned by the user. If this is not the correct interpretation of your requirement, we welcome further discussion.

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F-43	43.002	The system shall be able to input, modify , inactivate, delete, update, display, copy, and print critical incidents.	<p>Examples of Critical incidents Include: Critical incidents occurring in client's life or client care.</p> <p>Examples of Support Include: Data entry which "triggers" critical incident reporting / messaging according to staff responsibilities.</p> <p>Examples of Staff Responsibility Areas Include: Clinical, administrative, and financial.</p>	1						
F-43	43.004	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information of a personal task list.	<p>Examples of Information in a Personal Task List Include: Client appointments for the day; Staff meetings; QI reminders on record problems; Automated alerts (i.e., time to renew a service/Care Plan).</p> <p>The personal task list may be interfaced with third-party products.</p> <p>See 43.009, 43.010, and 43.012.</p>						1	
F-43	43.005	The system shall be able to input, modify , inactivate, delete, update, display, copy, and print documentation related to local policies and procedures.	Implies documentation may be accessed by standard office word processing software (E.g., Microsoft Word).	1						

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F-43	43.006	The system shall support efficient and user-friendly workflows.	<p>Efficient implies reducing staff time to complete system operation. User-friendly implies high user-acceptance of system interfaces and information displays.</p> <p>User-Acceptance May Include: Easy ability to navigate screens; add data record fields; interface to third-party software products (e.g., Microsoft Excel & Word); ability to have automatic updates of reference information (done through internal or external software linkages); ability to create / configure data displays, entry forms and system data linkages; etc.</p> <p>Examples of System Function Data Linkages Include: Scheduler may cause message routing, Assessments may engage access to Best Practice guidelines, Attempts to access data may cause messages to providers, Treatment data may be seen in Episode data screens.</p> <p>Displays and printing may be ad hoc or automated per business rules (unless otherwise stated).</p> <p>Example Workflow Areas Include: Quality management functions; Client, customer or provider satisfaction surveys; Complaint and compliment forms, Referral functions; and user-definable screen configurations or data fields, etc.</p>	1						

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F-43	43.009	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all required Workflow Business Rules.	<p>Examples of Business Rules Support Include: Workflows that are controlled or "guided" ("guided" implies user choice) by system implemented business rules.</p> <p>Example Business Rules Areas Include: Documents creation or manipulation; Following standard procedures related to critical incidents and staff advisories; Client pre-registration or registration; Client screening and admission; Client discharges; Client referrals; Client billing; Handling of client Medi-Cal Share of Cost; Client call logging; Referrals; Message, notification, alert, or document routing protocols; Signature acquisition protocols; Decision support; Diagnostic support; Workflow control; Access privilege; Data manipulation (e.g., creation, modification, deletion, inactivation, obsolescence, transfer, etc.); Audit trail management; Work assignments; Task lists; Human resources; Work prioritization; Work re-direction; Work reassignment; Client instructions linked to specific conditions (e.g., diagnosis, client preferences, etc.); "Escalation" of alerts, notifications, reminders, and tasks; etc.</p> <p>Examples of "Escalation" include forwarding information to supervisors / managers, display highlights, and increasing frequency of information display.</p>						1	Partially supported. Cerner's registration solution supports the ability to manually capture and maintain various referral related data. We do not delete Workflow Business Rules. The ability to support the Requirement Description for client billing is planned for our Revenue Cycle Ambulatory solution.
F-43	43.010	The system shall be able to enforce all Workflow Business Rules.		1						

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F-43	43.012	The system shall be able to input, modify, inactivate, delete, update, display, print, and route messages, alerts, notifications, and documents to system users, providers and clients.	<p>Examples of Information in Messages, Alerts, Notifications and Documents Include: Information, action, etc., are due or overdue, due dates; service / treatment authorizations; Incomplete client assessments, service/Care Plans, progress notes, or discharge summaries; Missing signatures; Loss of Third-Party Payor eligibility; Client advisories; Tasks information detail, Follow-up letters; Health information request; Etc;</p> <p>Alert configurations may include length of advance timing and who should be alerted.</p> <p>Examples of Support Include: Automated or manually created e-mails, text displaying in pop-ups, links to documents, Ad hoc and scheduled messages; Adherence to Best Practice standards; etc.</p>	1						Using our logic-based decision support solution, you can define alerts as on-screen notifications, printed reports, online messages, and notifications to pagers, inbox or email. Additionally, you can define required fields for each documentation form such as a discharge summary or client assessment. Until all required fields are completed the form remains in an "in process" status or your organization can define a form so that all required fields must be completed for the form to close. When required information is not entered, a window opens to assist and prompt the clinician for the required information.

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F-43	43.018	The system shall support client referrals.	Examples of support include: Referrals to Business Associates by HIPAA ASC X12N 278 - Referral Certification and Authorization format; Client referrals to other providers in same organization; Client referrals to other staff supporting client care, Client referrals to other county departments, etc.						1	Partially supported. With the implementation of Cerner's registration and benefits solutions the 278 transactions for Authorization are supported. Referrals are not supported.
F-43	43.021	The system shall support accessing community resource databases.	Examples of Support Include: Uploading or manual entry of community resources information into a searchable database that can be filtered based on user criteria; Integrating with or keeping community resource information separate from other organizational provider directories; etc.	1						Links to foreign data bases can be set up on users screens.
F-43	43.023	The system shall support moving clients from a Wait List to service / treatment.	Example of Support Includes: Tracking and sorting prospective clients by priority to assist in moving individual into service / treatment; etc.	1						This requirement is supported with waitlist functionality provided with Cerner's registration solution.
F-43	43.025	The system shall support a Grievance and Complaints system.							1	
F-43	43.026	The system shall support client admission and discharge.	Examples of Support Include: User-defined online admission/discharge forms; Episodic discharge due to automated driven reviews of client inactivity; Coordination of system function for client admissions and discharges occurring on same day; etc.	1						Cerner's registration solution provides auto-discharge and the actions of discharge and admit to assist in supporting this requirement.

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F-43	43.027	The system shall support transfers of client information.	Examples of Support Include: Real-Time and Batched information transfer; Transfers of data internal to EHR system; Transfer of data between Business Associates; Transfers that are HIPAA compliant; Culturally-appropriate information transfers; etc.	1						The ability to capture culturally-appropriate information transfers is supported with user-defined field functionality provided with Cerner's registration solution.
F-43	43.028	The system shall ensure that workflows are compliant with federal, state, and local laws, rules, and regulations.		1						Cerner assumes this requirement to mean admission and discharge workflows.
F-43	43.031	The system shall support 24-hour client care.	Examples of Support Include: Creation, modification, deletion, and review of client related data; Tracking of clients by unit, room and bed, and midnight bed checks; Using the information to generate daily room charges; Monitoring facility capacity and documents bed availability; Tracking of dietary requirements for each 24-hour patient by unit, room, and, bed; Dietary orders for the kitchen based on the dietary orders; Monitoring of client valuables placed in 24 hour care; etc.	1						
F-43	43.035	The system shall support single sign-on software products.	Implies maintaining internal security controls.	1						
F-43	43.037	The system shall be able to auto-populate data fields with client demographics.	May include user definition of which data will be auto-populated.	1						
Practice Management Totals:				112	26	0	4	0	20	

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			162	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	

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F-03	3.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all client problems information.	<p>Examples of problems information include: Problems Descriptions; Problems Lists; Diagnosis: Name; Coding; Active / inactive status; Associated information (e.g., admission, discharge, chronicity, acute/self-limiting, Etc.); Family type (E.g., ICD-9 CM, ICD-10 CM, SNOMED-CT, DSM-IVR; Etc.); ; Effective Start / Stop dates for diagnosis; Etc.</p> <p>Displays should be user-friendly (e.g., Display of both diagnosis code and name; option to display diagnosis description; Etc.)</p> <p>See Practice Management 43.006 and Infrastructure 43.040</p>	1						Patient data stored within the Cerner Millennium database is not deleted.
F-03	3.002	The system shall provide the ability to maintain a history of all problems associated with a client.	This means both current and inactive and/or resolved problems. These may be viewed on separate screens or the same screen. Ideally each discrete problem would be listed once.	1						
F-03	3.005	The system shall be able to record the user ID and date of all updates to documented client problems.		1						
F-03	3.006	The system shall be able to associate orders, medications, and care documentation (e.g., notes) with one or more problems.	<p>Implies ability to associate a visit with a particular diagnosis / problem.</p> <p>Association may be in a structured or non-structured data format.</p>	1						
F-03	3.009	The system shall be able to validate diagnosis information to be used in the system.	Examples of validation include: Diagnosis is valid for an associated axis; Diagnosis is active for an associated time period; User authorized to enter diagnosis information; Etc.	1						

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F-03	3.012	The system shall provide the ability to separately display active problems from inactive/resolved problems.		1						
F-03	3.013	The system shall support multiple diagnosis standards.	Examples include: DSM IV and ICD-9, ICD-10 diagnoses. Includes any necessary translations of code to code formats.	1						
F-03	3.016	The system shall be able to manually order a problem list.		1						

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F-04	4.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication lists information.	<p>Examples of medication lists include: Lists based on frequency of medication usage; healthcare service provider medication preferences; etc.</p> <p>Examples of medication list information include: Medication name; dose; route; sig,;dispense amount; refills; associated diagnoses; medication expiration date; medication labeling as ineffective for client, Date of any change made to medication information (including a medication list); Identification of user who made any change to medication information, etc.</p> <p>Implies medication information is stored in discrete data fields and only approved abbreviations shall be used.</p> <p>The medication list shall be "client-centric" and shall include medications prescribed by any provider.</p> <p>Display and printing of information may be controlled through user-selected parameters (e.g., client identifier, date ranges, which information to display, current and/or inactive medication status, brand or generic name of medication, etc.)</p> <p>See Practice Management 43.006 and Infrastructure 43.040</p>	1						Patient data stored within the Cerner Millennium database is not deleted.

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F-04	4.002	The system shall be able to indicate that the medication list has been reviewed by both the healthcare service provider and client.	Implies usage of a discrete data record field.	1						
F-04	4.003	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all prescribed medication-related information.	<p>Examples of information include: Client prescriptions; Prescribed medications; Non-prescribed medications (e.g., over the counter and complementary medications such as vitamins, herbs and supplements); Standard medication codes (e.g., NDC number codes); Free text or uncoded medications; Medication name, schedule, quantity, dosage, order date, date last taken, side effects, and effectiveness; Client identifiers; Medication start, end, and renewal dates; Refill quantity; Prescriber identity; Fact that client takes no medications; Reasons for taking, not taking, or discontinuing medication; Source of medication information or history; Date of any change made to medication information (including a medication list); Identification of user who made any change to medication information; Medication contra-indication, Active problem interaction; etc.</p> <p>Implies medication information is stored in discrete data fields and only approved abbreviations shall be used.</p> <p>Copying implies ability to "cut and paste" or otherwise import / export medication information with another data</p>	1						Patient data stored within the Cerner Millennium database is not delete

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F-04	4.005	The system shall support medication monitoring.	Examples of support include: User-friendly linkage/navigation to Diagnostic Test Order screens; Provider notification when test results are obtained; Etc. Linked to 14.001	1						
F-04	4.007	The system shall be able to display and print medication history for the client.	Examples of medication history include: Client system identifier and name; medication name, frequency, effective start date and end date, and dosage; Range of dates for history.	1						
F-04	4.011	The system shall provide the ability to enter non-prescription medications, including over the counter and complementary medications such as vitamins, herbs and supplements.	This is important for interaction checking, associating symptoms with supplements e.g. the L-tryptophan related eosinophila-myalgia syndrome	1						
F-04	4.013	The system shall be able to exclude a medication from the current medication list and document the reason for such action.	Exclusion examples include: medications marked inactive, erroneous, completed, discontinued. Documentation includes identifying the clinical authority authorizing exclusion.	1						
F-04	4.025	The system shall be able to notify healthcare service providers that client's prescribed medication might be running out.	Implies controlling notifications through business rules; Queries that search for expiring/expired prescriptions; Etc.	1						

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F-04	4.026	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication information in any medication formulary list.	Examples of lists include: Medication formulary for entire organization; Medication formulary defined by client classification, funding, Scope of Practice, Etc. Example of information in lists include: Medication name; Type of list (e.g., agency wide, client classification specific, Etc.); Medication choice prioritization; Medication costs: Etc..	1						The medication formulary list can be modified, inactivated, updated, displayed, copy and printed. Medication costs can be displayed within our Pharmacy solution, an optional offering. Patient data stored within the Cerner Millennium database is not deleted.
F-04	4.027	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication formulary rules and guidelines.	Examples of rules include: List access; Formulary usage is optional or required criteria; Effective stop / start dates of formulary usage; Etc. Guidelines may be reference documents.	1						Patient data stored within the Cerner Millennium database is not deleted.
F-04	4.028	The system shall include access to the National Drug Code (NDC) database.		1						
F-04	4.029	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print commonly used prescription templates.	Examples of prescription templates include: Templates defined for different healthcare service providers; Etc.	1						
F-04	4.037	The system shall support client involvement in a Physician Assistance Program (PAP).	Examples of support include: Prompting a healthcare service provider to discuss participation with the client; Providing data fields to record information on client's involvement; Providing reminders when the application renewal is due; Etc. See Practice Management 32.016	1						

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F-05	5.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information on medications and other agents to which the client has had an allergic or other adverse reaction.	<p>Examples of information include: Any combination of provider / client defined allergy / adverse reactions lists; Client identifiers; Medication names; Type and severity of allergic or adverse reaction; Reason and authority for action taken on information (i.e., modification, inactivation, Etc.); Date action taken on information; User identifier who took action on information; Source references for information (e.g., Client, relative, friend, healthcare service provider, etc.)</p> <p>"Inactivate" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely. The user ID, date & time will be recorded per Security requirements.</p> <p>See Practice Management 43.006 and Infrastructure 43.040</p>	1						Patient data stored within the Cerner Millennium database is not deleted.
F-05	5.009	The system shall be able to document review of any allergy or adverse reaction list.	<p>Examples of review documentation include: Reviewer User Identifier; Date stamp of when review option is selected.</p> <p>Medico-legal and regulatory compliance. This requires the user to explicitly select this option documenting that they have reviewed the allergies with the client.</p> <p>Implies documentation will be in a structured format.</p>	1						

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F-05	5.011	The system shall be able to explicitly indicate that a client has no known drug allergies.	Medico-legal and regulatory compliance. This is meant to be specific to drug allergies. Expected to be available by 2008.	1						
F-05	5.012	The system shall be able to explicitly indicate that a client has no known non drug allergies.	Expected to be available by 2008.	1						
F-05	5.015	The system shall be able to check for potential interactions between a current medication and a newly entered allergy.		1						
F-05	5.016	The system shall interface with third party databases that support automated drug allergy checking to be performed during the medication prescribing process.		1						Cerner utilizes MediSource for drug allergy checking. MediSource is a comprehensive, computerized drug interaction database. This robust database is a product of Multum Information Services, Inc., a wholly owned subsidiary of Cerner Corporation.
F-05	5.017	The system shall provide the ability to capture non-drug agents to which the client has had an allergic or other adverse reaction.	These could include items such as foods or environmental agents. This need not be accomplished within the same portion of the chart where medication allergies are noted.	1						

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F-06	6.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client history information.	<p>Examples of client history include: Services / Treatments; Healthcare service provider identifiers; Medical conditions; Diagnoses; Medical procedures; Immunizations; Date / Times of actions on history data (i.e., additions, modification, inactivation, etc.); Family history; Social history; Hospitalizations; Specific absence of a condition or family history of the condition; Reason and authority for action taken on information (i.e., modification, inactivation, etc.); Date action taken on information; User identifier who took action on information; Source references for information (e.g., Client, relative, friend, healthcare service provider, etc.); Episodes of care; Prior client or provider alerts, vital signs recordings, client messages, chronic diseases, Post discharge contact information; etc.</p> <p>Episodes of care are based on state and local definitions. Generally, they are by periods of care at a provider, geographical, or organizational level; They may be outpatient or inpatient based and may exist concurrent with other episodes of care.</p>	1						Patient data stored within Cerner Millennium database is not deleted.
F-06	6.002	The system shall capture client history information in a structured data format.		1						
F-07	7.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print summary list information for each client.	Data may be in a standard and non-standard coded form.	1						Patient data stored within Cerner Millennium database is not deleted.

Examples of provider documentation include information in: Healthcare service provider assessments, notes, care plans, progress notes,

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F-08	8.001	<p>The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all healthcare service provider documentation in system.</p> <p>All actions on documentation shall cause a recording of the date / time of the action and the identity of the user who performed the action.</p>	<p>Examples of provider documentation include information in: Healthcare service provider assessments, notes, care plans, progress notes, wellness and recovery plans, Etc.</p> <p>Examples of documentation information include: Client name, Identifier of who entered data, age, gender, problem(s), medical necessity, current and prior healthcare service providers, risk factors, family medical history; Physical health attributes (e.g., client vital signs, blood pressure; temperature; heart rate, respiratory rate, height, and weight, and physical pain levels); Free text notes; Nationally recognized mental/behavioral health care plans and alerts; Language used by client; provider's explanation (and the client understanding) of recommended and/or alternative care plans; Actions taken to safeguard the client to avert the occurrence of morbidity, trauma, infection, or condition deterioration; Problem lists for adults and children; Global Assessment of Functioning (GAF) values; Children Global Assessment Scale (CGAS) scores; Etc.</p> <p>Examples of actions include: input, modify, inactivate, delete, update, display, copy, and print actions. It also includes "finalization" of healthcare service provider sets of documentation as listed above. Input may be by client and provider. (CONTINUED ON NEXT PAGE)</p>	1						<p>Patient data stored within Cerner Millennium database is not deleted.</p>

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			<p>Examples of display include: Filtered / sorted by various criteria (e.g., Provider who finalized the note; Diagnosis, Etc.)</p> <p>Conversion of information to numeric values that can be graphed enhances interoperability and for public health surveillance or clinical research..</p> <p>Examples of numeric coding are found in ICD-9 CM, ICD-10 CM, SNOMED, UMLS, etc.,</p> <p>See Practice Management 43.006 and Infrastructure 43.040.</p>							
F-08	8.003	The system shall be able to save, and later retrieve, healthcare service provider documentation in progress.	Display of information may include linkages to multiple system database records (e.g., Diagnosis, Allergies, Service / Treatment, etc.)	1						
F-08	8.005	The system shall be able to finalize healthcare service provider documentation, i.e., change the status of the documentation from in progress to complete.		1						
		Subsequent actions will not destroy any of the original finalized documentation, i.e., strikeouts, addendums, etc., will be used instead of text destruction.								
F-08	8.007	The system shall support electronic signatures and co-signatures in documentation.	See Practice Management 43.006 and Infrastructure 43.040	1						
F-08	8.008	The system shall be able to addend to documentation that has been finalized.		1						

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F-08	8.009	The system shall be able to identify, display and print the full content of a modified documentation.	Implies display and printing of both the original content and the content resulting after any changes, corrections, clarifications, addenda, etc. to a finalized documentation.	1						Your organization can determine whether to display or hide modified data.
F-08	8.015	The system shall be able to graph client attributes over time.	Examples include: height and weight; Calculated body mass index (BMI); Etc.	1						
F-08	8.017	The system shall be able to compare body mass index (BMI) to standard norms for age and sex over time.		1						
F-08	8.018	The system shall be able to indicate to the user when a vital sign measurement falls outside a preset normal range.	Implies that authorized users shall set the normal ranges.	1						
F-08	8.019	The system shall be able to associate standard codes with discrete data elements in a documentation.	Examples of standard codes include but are not limited to SNOMED-CT, ICD-9 CM, ICD-10 CM, DSM-IV, CPT-4, MEDCIN, and LOINC. This would allow symptoms to be associated with SNOMED terms, labs with LOINC codes, etc. The code associated with a note would remain static even if the code is updated in the future.	1						
F-08	8.020	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print structured templates for healthcare service provider documentation.	Examples of templates include: Structured progress notes; Intake assessments such as the mini mental health exam; Care Plans; Wellness and Recovery Plans; Etc. User ability to customize templates is preferred. Codified data are data that is structured AND codified according to some 'external' industry accepted standard such as ICD-9 CM, ICD-10 CM, SNOMED-CT, and CPT-4.	1						Patient data stored within the Cerner Millennium database is not deleted.

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<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
F-08	8.023	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print comments by the client or the client's representative (henceforth 'client annotations') regarding the accuracy or veracity of information in the client record.	This includes external documentation incorporated in the client records. 2007 it is sufficient for these to be recorded as either free-text notes (see item F59) or scanned paper documents (see item F86). It is not required that the system facilitate direct entry into the system by the client or client's representative.	1						Patient data stored within the Cerner Millennium database is not deleted.
F-08	8.024	The system shall display client annotations in a manner which distinguishes them from other content in the system.	Examples of displays include: Use of a different font or text color; A text label on the screen indicating that the comments are from a client or client's representative; Etc. "Distinguishable" refers specifically to comments made by the client or client's representative, but does not refer to the individual components of that chart with which they are in disagreement.						1	As we have interpreted your question clinicians can distinguish in a form or note that the client or client's representative has provided the information; however, the text will not be displayed in different colored text or font.
F-08	8.025	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client or client proxy completed clinical information.	Once verified by a healthcare service provider and shared with other parts of the chart, the shared data does not need to be identified as client completed in all sections where data may be shared, but the original client completed information shall be maintained.	1						As we have interpreted your request, the client completed documentation can be scanned and/or documented into the clinical data repository. Once patient data is verified and stored within the Cerner Millennium database it can not be deleted.

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F-08	8.027	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print group activity documentation.	Examples of group activity include: Outpatient and Inpatient group therapy sessions; Group therapy sessions funded by multiple funding streams (E.g., Mental Health / Alcohol and Drug); Etc. Implies the ability to handle both documentation common to all participants and documentation distinct to an individual participant.	1						Patient data stored within the Cerner Millennium database is not deleted.
F-08	8.035	The system shall be able to interface with 3rd party products which support documentation.	Examples of products include: Various standard intake assessment instruments; Medical dictionary; Etc.	1						

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F-08	8.044	The system shall provide a location check log that supports the tracking of clients by location.	Examples of client checking include: Client checking on a user-defined basis (e.g. every 5 or 10 minutes). This component is used primarily at inpatient facilities.	1						Within Access Office Bedboard or a registration conversation, the ability to assign or remove the assignment of a Temporary Location to a patient is supported. Within the Bedboard, the patient displays in the assigned nurse unit/room/bed. A Temporary Location column is available that can be added as a Bedboard column to view the Temporary Location of the patient. Additionally, your organization can define a user defined field to designate the status of the patient. User defined fields can also be added as Bedboard columns. Tracking of patients from Preadmission to Discharge, the location history is viewable for the patient in PMLocHist or using the History Maintenance Module in Access Office. The Dirty

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F-08	8.047	The system shall be able to merge client healthcare service provider documentation.	Examples of reasons for merge include: Documentation created under two separate client identifiers but its really for the same client. Does not have to be only duplicate data found in both records.	1						Cerner's combine process updates the encounters from the person being combined away to be moved to the person being combined into. Therefore all data with that encounter will be retained and tied to the remaining person record. Additionally, single documents can be moved to a new encounter without moving the entire encounter.
F-08	8.048	The system shall be able to display and review all data in two similar type client healthcare service provider documentation records for the same client, identifying the data that is different.	This will support determining the correct client health record information that should exist subsequent to merging two records to one.	1						Cerner's combine tool provides side by side viewing of person information such as date of birth, gender, address, phone number, aliases, and health plan information prior to performing a person combine.
F-08	8.049	The system shall require user confirmation prior to merging any client healthcare service documentation.		1						Moving documentation is a manual process with multiple verification steps.

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F-08	8.050	The system shall be able to recreate as separate documentation records previously merged client healthcare service provider documentation.		1						The process would be to in-error the document and move or copy again.
F-08	8.064	The system shall support healthcare service provider Report Dictation.	Examples of support include: Voice capture and storage; Routing of voice to transcribers; Integration of audio files with documentation; Usage across various parts of EHR system; Software produced voice to text transcriptions; Usage of nationally recognized best practice dictation software solutions; Etc. Also supported by 8.001 and Infrastructure 43.040	1						Physician Documentation provides the ability for the clinician to launch a dictation session, record a note, and save the file to the patient record. This is known as HotSpot Dictation. The dictated audio file is available for review until the actual transcribed note is complete. Once transcribed, the text populates in place of the audio file. Additional licensing of Cerner's Millennium Objects is also required.
F-08	8.074	The system shall provide the ability to capture other clinical data elements, such as peak expiratory flow rate, size of lesions, severity of pain, as discrete data		1						

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F-08	8.075	The system shall provide the ability to display other discrete numeric clinical data elements, such as peak expiratory flow rate or pain scores, in tabular and graphical form.	Listed items are examples only.	1						
F-09	9.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print external healthcare service provider documentation.	<p>Examples of external documents or their content include: Scanned documents; Electronically submitted documents (e.g., faxes; downloads; etc.); Structured reports (e.g., text-based fields; standard and non-standard codified data, etc.) ; Referral authorizations; Consultant reports; Client correspondence of a clinical nature; External test results (e.g., Labs; X-rays; Physical exams, etc.); Medication detail (e.g., Pharmacy, client, and provider identifiers, medication strength, dosage, Dr. directions; etc.); Originator of document; Etc.</p> <p>Examples of input documents formats include: Storing as a file of various electronic formats (E.g., .PDF, .Doc, .XLS, .JPG, .TIF, .MPEG, .WAV, .MP3, etc.); Integrating as text or image documents into EHR records / screens; integration through web-links; Etc.</p> <p>Images may include but are not limited to radiographic, digital or graphical images.</p> <p>Examples of document support for EHR system include: Indexing (for retrieval) methodologies; Web-links; Date / Time stamping; Etc.</p> <p>See Practice Management 43.006 and Infrastructure 43</p>	1						Patient data stored within the Cerner Millennium database is not deleted.

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F-09	9.005	The system shall be able to index documents.	Examples of types of indexing include: Document type; Date of the original document; Date of scanning; Subject and title.	1						
F-10	10.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client instructions and client educational materials.	Examples of client instructions and educational materials include: Medication instructions; Tests and procedures instructions; Vaccine instructions; Care access instructions; Etc.) Implies material would be culturally competent and in county threshold languages. See Infrastructure 43.040 and Practice Management 43.006	1						
F-10	10.004	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print that client specific instructions or educational material were provided to the client.	Implies material would be culturally competent and in county threshold languages. This does not require automatic documentation.	1						
F-10	10.010	The system shall be able to link client instructions to other system functions and enable automated printing of instructions.	Examples of system functions include: Management of client care plans, client orders, client scheduling, provider practice guidelines; Etc.	1						

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F-10	10.012	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print a Crisis Management Plan.	<p>Implies that: Plan structure may defined by user; Plan may be prepared by the client and their case manager.</p> <p>Implies integration with other system functions.</p> <p>If a client goes into crisis this plan is easily accessible to provide guidance to staff on the care team and other providers who have contact with the client.</p> <p>See Practice Management 43.006</p>	1						Patient data stored within the Cerner Millennium database is not deleted.
F-10	10.013	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print an Advance Directives Plan.	<p>Examples of advance directives include: Client healthcare service provider preferences; Medication limitations; notifications to relatives or guardians; Etc.;</p> <p>Implies that: Plan structure may defined by user; Plan may be prepared by the client and their case manager.</p> <p>Implies integration with other system functions.</p> <p>If a client goes into crisis this plan is easily accessible to provide guidance to staff on the care team and other providers who have contact with the client.</p> <p>See Practice Management 43.006</p>	1						Patient data stored within the Cerner Millennium database is not deleted.

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F-14	14.001	The system shall provide the ability to input, modify, inactivate, delete, update, display, copy, and print results information.	<p>Examples of results information include: Client identifier(s); Linkage to original order information; Test and Result types; Test dates; Result source; Result receipt date; Result type: (E.g., X-ray, lab, vital sign; Etc.); Result status (E.g., normal vs. abnormal status by county definition and/or original data source definition); Effective start/stop date; Result related documentation (E.g., Image documents, Consultation notes, Diabetes education; Etc.); Client or provider commentary regarding results; alerts identifying a modification to the test or procedure; Etc.</p> <p>Displays may be as numeric or textual data and sorted / filtered by variable criteria (client group identifier, client identifier or multiple client identifiers, test type, test date, normal/abnormal status, etc.); Abnormal data may be highlighted for ease of viewing;</p> <p>See Practice Management 43.006 and Infrastructure 43.040</p>	1						Patient data stored within the Cerner Millennium database is not deleted.

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F-14	14.002	The system shall be able to compare results over time.	<p>Examples of result comparisons include: A clients test results to client's own baseline results, organizational baseline results; prior client results, other client results, national standards results, comparisons with prescription and other client data in system; Visual comparison of lab results to prescription information, Etc.;</p> <p>Display may be in numeric flow sheets and/or graphical form.</p> <p>System should indicate if abnormal results are high or low.</p>	1						
F-14	14.007	The system shall be able to forward a result.	Examples of who may receive the forwarded result include: healthcare service providers; the client; Etc.	1						

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F-16	16.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print care plan, protocol, and guideline documents.	<p>Examples of guideline documents include: Standard documents; Site-specific documents; Clinical Trial Protocols;</p> <p>Psycho-social assessments, Intake assessments, Addiction Severity Index (ASI), inpatient evaluations, Residential placement evaluations; Etc.</p> <p>Clinical trial protocols may be used to ensure compliance.</p> <p>These documents may reside within the system or be provided through links to external sources. They may be nationally recognized documents.</p> <p>This requirement could be met by simply including links or access to a text document. Road map would require more comprehensive decision support in the future. This includes the use of clinical trial protocols to ensure compliance.</p> <p>See Practice Management 43.006 and Infrastructure 43.040.</p>	1						Patient data stored within the Cerner Millennium database is not deleted.
F-17	17.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print the reason for variation from care plans, guidelines, and protocols as discrete data.	See Practice Management 43.006 and Infrastructure 43.040.	1						Patient data stored within the Cerner Millennium database is not deleted.

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F-19	19.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication administration information.	Example of medication administration information includes: Medication type; Dose; Time of administration; Route; Site; Lot number; Expiration date; manufacturer; Person who administered medication; Data entry user ID. Data shall be stored as discrete data fields. See Practice Management 43.006 and Infrastructure 43.040.	1						Patient data stored within the Cerner Millennium database is not deleted.
F-19	19.003	The system shall provide the ability to document immunization administration.		1						
F-19	19.004	The system shall provide the ability to document, for any immunization, the immunization type, dose, time of administration, route, site, lot number, expiration date, manufacturer, and user ID as structured documentation.		1						
F-19	19.005	The system shall provide the ability to record an adverse reaction to a specific immunization.	Immunization allergies may be indicated in the Allergy section.	1						
F-19	19.006	The system shall provide the ability to alert a user at the time of ordering that the client had a prior adverse reaction to that immunization.		1						Clinicians can be notified provided that the adverse reaction was previously noted in the allergy profile.

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F-21	21.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information on criteria guidelines for disease management, preventive services, and wellness alerts.	<p>Examples of criteria information include: Client demographic data (minimally age and gender); Clinical data (e.g., problem list, current medications, Etc.);</p> <p>Implies that guidelines are interfaced with organization's business rules.</p> <p>The criteria guidelines may: Be internal or external based; Use clinical trial protocols to ensure compliance; Cause automatic and proactive alerts (e.g., contact care provider without physician intervention); Come from national organizations, medical societies, etc.</p> <p>See Practice Management 43.006, 43.009, 43.010 and Infrastructure 43.040.</p>	1						Patient data stored within the Cerner Millennium database is not deleted.
F-21	21.002	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print alerts based on established guidelines.	<p>Guidelines may be from national organizations, payers, or internal protocols.</p> <p>See Practice Management 43.012</p>	1						Patient data stored within the Cerner Millennium database is not deleted.
F-21	21.006	The system shall be able to override guideline alerts.	Includes all or part of the alerts.	1						
F-21	21.007	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print reasons alerts were overridden.	Needed for medico-legal reasons and clinical decision support.	1						Patient data stored within the Cerner Millennium database is not deleted.

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F-21	21.009	The system shall trigger clinical alerts that present urgent clinical information.	<p>Examples of urgent clinical information include: Danger warnings, suicide watch or similar, drug allergies, history of adverse reactions to specific drugs, and other urgent precautions.</p> <p>Examples of alerts types include: Clinical alerts for incarcerated clients (e.g., suicide watch, drug dealing, and protective custody</p> <p>Alerts to be viewed at various key screens including those that handle progress notes, appointments and service/Care Plans.</p> <p>See Practice Management 43.009, 43.010, and 43.012.</p>	1						
F-21	21.022	The system shall provide the ability to document that a preventive or disease management service has been performed based on activities documented in the record (e.g., vitals signs taken).		1						
F-21	21.023	The system shall provide the ability to document that a disease management or preventive service has been performed with associated dates or other relevant details recorded.	This could include services performed internally or external to the practice.	1						

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F-21	21.024	The system shall provide the ability to document that a disease management or preventive service has been performed with associated dates or other relevant details recorded.	This is done at the client level. Examples include but are not limited to: *Remove mammography for woman that has had a mastectomy *Remove annual pap smear alert for a woman who has had a complete hysterectomy. *Inactivate an alert for routine colon cancer screening in a client who is terminally ill.	1						
F-22	22.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print criteria information for disease management, preventative services, and wellness notifications and reminders.	Examples of criteria information include: Client demographic data (minimally age and gender); Clinical data (e.g., problem list, current medications, Etc.) Implies guidelines are interfaced with organization's business rules. The criteria guidelines may: Be internal or external based; Use clinical trial protocols to ensure compliance; Cause automatic and proactive notifications and reminders (e.g., contact client without physician intervention); Come from national organizations, medical societies, etc. See Practice Management 43.006, 43.009, 43.010 and Infrastructure 43.040.	1						Patient data stored within the Cerner Millennium database is not deleted.
F-22	22.002	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print notifications and reminders based on established guidelines.	Guidelines may be from national organizations, payers, or internal protocols. See Practice Management 43.012	1						Patient data stored within the Cerner Millennium database is not deleted.

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F-22	22.004	The system shall trigger clinical notifications and reminders.	Examples of clinical notifications and reminders include: One or more clients are due or overdue for disease management, preventive, or wellness service / treatments; See Practice Management 43.009, 43.010, 43.012, and Infrastructure 43.040.	1						
F-22	22.007	The system shall be able to override guideline notifications and reminders.	Includes all or part of the notifications and reminders.	1						
F-22	22.009	The system shall provide the ability to display reminders for disease management, preventive, and wellness services in the client record.	It is expected that in the future discrete data elements from other areas of the chart will populate matching fields.	1						
F-22	22.010	The system shall provide the ability to identify criteria for disease management, preventive, and wellness services based on client demographic data (age, gender).		1						
F-29	29.001	The system shall be able to define one or more reports as the formal Health Record for disclosure purposes.	This allows the practice to not print demographics, certain confidential sections, or other items. Report format may be plain text initially. In the future there will be a need for structured reports as interoperability standards evolve.	1						
F-29	29.002	The system shall be able to generate hardcopy or electronic output of part or all of the individual client's Health Record.	This could include but is not limited to the ability to generate standardized reports needed for work, school, or athletic participation.	1						
F-29	29.003	The system shall be able to generate Health Record hardcopy and electronic output by date and/or date range.		1						

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F-29	29.004	The system shall be able to export structured data which removes those identifiers listed in the HIPAA definition of a limited dataset. This export on hardcopy and electronic output leaves the actual PHI data unmodified in the original record.	De-identifying data on hardcopy or electronic output is necessary for research. However, it is emphasized that this function is not intended to cleanse the text in the note or data in the original record. As per HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, identifiers that shall be removed are: 1. Names; 2. Postal address information, other than town or city, state and zip code; 3. Telephone numbers; 4. Fax numbers; 5. Electronic mail addresses; 6. Social security numbers; 7. Health record numbers; 8. Health plan beneficiary numbers; 9. Account numbers; 10. Certificate/license numbers; 11. Vehicle identifiers and serial numbers, including license plate numbers; 12. Device identifiers and serial numbers; 13. Web Universal Resource Locators (URLs); 14. Internet Protocol (IP) address numbers; 15. Biometric identifiers, including finger and voice prints; and 16. Full face photographic images and any comparable images.	1						Printing features within Clinical Reporting include Distribution routing, Manual and auto expedites, and Report requests (Ad hoc or on-demand). Report Request functionality gives the client the ability to print portions of the longitudinal medical record, selection of specific encounters and time frames with the ability to print to specific internal or external parties. This functionality logs all pertinent information about the release of information, meeting HIPAA requirements.

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F-29	29.006	The system shall have the ability to provide support for disclosure management in compliance with HIPAA and applicable law.	This criterion may be satisfied by providing the ability to create a note in the client's record. More advanced functionality may be market differentiators or requirements in later years.	1						
F-30	30.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all client service / treatment information.	Examples of service / treatment information include: Information entry by keyboard; Structured data entry utilizing templates, forms, pick lists or macro substitution; Dictation with subsequent transcription of voice to text, either manually or via voice recognition system. See Infrastructure: 43.040.	1						We support dictation through an interface to a third party dictation system. Additionally, Hot Spot Dictation provides an alternative to "keyboarding" free text. Using Hot Spot Dictation the clinician can digitally dictate directly into the note via the embedded audio control. The resulting audio file can then be submitted for transcription and subsequent authentication. Patient data stored within the Cerner Millennium database is not deleted.
F-30	30.003	The system shall be able to associate individual service / treatments with diagnoses.		1						

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F-30	30.004	The system shall have the ability to provide filtered displays of service / treatments.	Examples of filtered displays include: Display by date of service; healthcare service provider; associated diagnosis; Etc.	1						
F-34	34.001	The system shall be able to update the clinical content or rules utilized to generate clinical decision support notifications, reminders and alerts.	Growth charts, CPT-4 codes, drug interactions would be an example. Any method of updating would be acceptable. Content could be third party or customer created.	1						
F-34	34.002	The system shall be able to update clinical decision support guidelines and associated reference material.	Any method of updating would be acceptable. Content could be third party or customer created.	1						
I-04	4.001	The system shall be able to send a report of client immunizations to an immunization registry	State immunization registries are not using uniform national standards at this time. The CVX and MVX vocabularies constitute an option for representing immunizations, but have not been addressed by HITSP at this time. Working Group will evaluate standards and options for future versions of HL7.	1						Cerner's integrated EMR contains many of the functions needed for registries. We can send HL7 ADT messages using an interface to a immunization register or send the data via extracts. We are currently working on additional capabilities to support registries but no release date has been announced.

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Clinical Data - Cerner Corporation

<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
I-04	4.002	The system shall be able to retrieve immunization registry information and import immunization record information into the EHR	State immunization registries are not using uniform national standards at this time. The CVX and MVX vocabularies constitute an option for representing immunizations, but have not been addressed by HITSP at this time. Working Group will evaluate standards and options for future versions of HL7.	1						We support outgoing unsolicited immunization transactions using the HL7 VXU message. We also support an upload of immunization history from a legacy system into the Cerner Millennium database.

Clinical Data Totals:

			<i>Number of Requirements</i>	97	0	0	0	0	1	
			98	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	

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Computerized Provider Order Entry(CPOE) - Cerner Corporation

<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
F-04	4.009	The system shall be able to input, modify, inactivate, delete, update, display, and print medication history received electronically.	Medication history examples include: Medication prescription history.	1						
F-11	11.001	The system shall be able to input, modify, inactivate, delete, update, display, and print information for prescription or other medication orders which meet State Board of Pharmacy requirements for correct filling and administration by a pharmacy.	Implies an ordering sub-system with all necessary data to complete an order, and other functionality such as pending orders, etc. The term pharmacy here refers to all entities which fill prescriptions and dispense medications including but not limited to retail pharmacies, specialty, and mail order pharmacies. See Clinical 4.003 and Practice Management 4.006.	1						
F-11	11.002	The system shall be able to record user and date stamp for prescription related events.	Examples of prescription related events include: Initial creation, renewal, refills, discontinuation, and cancellation of a prescription.	1						

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<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
F-11	11.004	The system shall allow authorized individuals to sign and cosign medication orders.	The words, "sign," "signature," "cosign," and "co signature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criterion calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.	1						
F-11	11.007	The system shall be able to maintain a coded list of medications and correlate the medications to NDC numbers.	For clarification - Coding means a unique identifier for each medication.	1						
F-11	11.009	The system shall be able to check for daily dose outside of recommended range for client age (e.g., off-label dosing).	Year to be determined once e-prescribing sig requirements have been defined.	1						
F-11	11.010	The system shall be able to check for dose ranges based on client age and weight.		1						
F-11	11.011	The system shall be able to select a drug by therapeutic class.	As available through 3rd-party drug databases.	1						

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F-11	11.012	The system shall be able to electronically verify client prescription eligibility and receive, display, store and update information received accordingly.	Will be required by e-prescribing. This criterion shall maintain a record of whether the client was eligible for coverage in the system.		1					We are developing eligibility, formulary, and medication history through SureScripts.
F-11	11.013	The system shall be able to input, modify, inactivate, delete, update, display, and print information received through review of health plan/payer formulary.	If this review included medications already on the medication list, a duplicate record in the medication shall not be created (same date, medication, strength, and prescriber). Formulary checking refers to whether a particular drug is covered.-		1					We are developing the Formulary & Benefits standards which will be released with our next major release.
F-11	11.014	The system shall be able to reorder a prior prescription without re-entering previous data (e.g. administration schedule, quantity).		1						
F-11	11.015	The system shall be able to print and electronically fax prescriptions.	Appropriate audits and security shall be in place.	1						
F-11	11.016	The system shall be able to re-print and re-fax prescriptions.	This allows a prescription that did not come out of the printer, or a fax that did not go through, to be resent/reprinted without entering another prescription. Appropriate audits and security shall be in place.	1						

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F-11	11.017	The system shall be able to send prescriptions electronically, including ability to document source of prescription order (e.g., "phone in" orders).	Prescription information includes: Structured and coded Sig. instructions. This implies: Pharmacy is capable of receiving electronic prescriptions (e-prescribing and not faxing); There is formulary compliance capability (e.g., RXHub); System is able to receive prescription update information from pharmacy (e.g., prescription filled); Etc.	1						The ability to send prescriptions electronically within the Cerner domain is supported with our Orders and Retail Pharmacy solutions, an optional offering.
F-11	11.018	The system shall be able to display a dose calculator for client-specific dosing based on weight and age.	This allows the user to enter pertinent information to calculate doses. This would be an interim step until databases are available to calculate doses automatically.	1						
F-11	11.019	The system shall be able to display client specific dosing recommendations based on age and weight.	This would calculate automatically from pertinent information in the chart (age and weight) and shall be in standard units and based on a standard periodicity. This is contingent upon availability of databases. We encourage their rapid development.	1						
F-11	11.020	The system shall be able to display client specific dosing recommendations based on renal function.	On roadmap for 2010	1						

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F-11	11.021	The system shall have the ability to receive and display information about the client's financial responsibility for the prescription.	This could include co-payments or tier level of the drug obtained through an interface with a pharmacy benefits manager (PBM).		1					We are developing the Formulary & Benefits standards which will be released with our next major release. Our Retail pharmacy solution, an optional offering, supports this through adjudicating the claim real time through the NCPDP claims standard to the PBM plan to determine coverage, copay, and reimbursement.
F-11	11.022	The system shall be able to identify any medication dispensed (including samples), documenting lot number and expiration date.	Lot numbers and expiration date could be entered in free text or encoded.	1						
F-11	11.023	The system shall be able to prescribe fractional amounts of medication (e.g. 1/2 tsp, 1/2 tablet).	Very important to prescribing for pediatric and geriatric clients.	1						
F-11	11.024	The system shall be able to prescribe non-NDC coded medications.		1						If a medication is needed that is not in the formulary/ order catalog, clinicians can use a free text order to order the non-formulary medication.

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F-11	11.028	System shall be able to allow the user to configure prescriptions to incorporate fixed text according to the user's specifications and to customize the printed output of the prescription.	This refers to the "written" output and language on the prescription such as specific language, dispense as written. For instance, users shall be able to modify the format/content of printed prescriptions to comply with state Board of Pharmacy requirements.	1						
F-11	11.029	The system shall be able to associate a diagnosis with a prescription.		1						
F-11	11.030	The system shall be able to display the associated problem or diagnosis (indication) on the printed prescription.	At least one diagnosis shall be able to be displayed but the ability to display more than one is desirable. Associated problem or diagnosis can be non-structured data or structured data.	1						
F-11	11.031	The system shall provide links to general prescribing information at the point of prescribing.	Example: Physician Desk Reference (PDR)	1						
F-11	11.032	The system shall be able to create user-defined specific medication lists of the most commonly prescribed drugs with a default dose, frequency, and quantity.	"User-defined" refers to medical staff and support staff that utilizes the lists.	1						
F-11	11.033	The system shall be able to add reminders for necessary follow up tests based on medication prescribed.	This does not imply that this shall be an automated process.	1						

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F-12	12.001	The system shall be able to input, modify, inactivate, delete, update, display, and print order information for diagnostic tests, including labs and imaging studies.	<p>Examples of orders information include: Client identifiers; Ordering provider; Order type (e.g., diagnostic test, lab work, imaging studies, etc.); One or more associated problems or diagnoses; Order status (e.g., complete, incomplete, etc.); Etc.</p> <p>Implies an ordering sub-system with all necessary data to complete an order, and other functionality such as pending orders, etc.</p> <p>It is desirable that all information for medical necessity checking be captured.</p> <p>This includes physicians and authorized non-physicians.</p> <p>See Practice Management 43.006.</p>	1						
F-12	12.002	The system shall be able to associate a problem or diagnosis with the order.	May associate more than one problem or diagnosis with the order.	1						

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<i>Req. Ctgy.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
F-12	12.004	The system shall be able to capture applicable signatures and co-signatures for all test orders.	The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criterion calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.	1						
F-12	12.006	The system shall be able to display user created instructions and/or prompts when ordering diagnostic tests or procedures.	Refers to diagnostic test or procedure specific instructions and/or prompts; not client specific instructions and/or prompts. Instructions and/or prompts may be created by the system administrator. A 3rd party product may be used, providing that the instructions and/or prompts appear at the point of care.	1						
F-12	12.007	The system shall be able to transmit orders for a diagnostic test to the correct internal or external destination for completion.	Mechanisms for relaying orders may include providing a view of the order, sending it electronically, or printing a copy of the order or order requisition.	1						
F-12	12.009	The system shall be able to display or print orders by like or comparable type, e.g., all radiology or all lab orders.	May include filters or sorts.	1						

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F-12	12.012	The system shall be able to validate lab work order information.	Examples of validation include: Medical Necessity exists; Test order compliant with business rules; Etc.	1						Medical Necessity is the criterion for Medicare to determine whether provider services can be reimbursed by the government. To determine eligibility for reimbursement, each Medicare Fiscal Intermediary (FI) and carrier compiles state specific lists of diagnosis codes to identify and support each billed service. These lists define medical necessity and are published by Local Medical Review Policies (LMRP). LMRP content is available through a subscription. 3M is a third-party content supplier that provides LMRP data for many FIs across the country. 3M compiles Medical Necessity Dictionaries containing the CPT-to-ICD-9 combinations that constitute the LMRP. The Medical Dictionaries are transmitted by 3M in electronic ASCII text format to Cerner. Cerner provides the Medical Necessity content directly to the client in a format compatible with the client's Health Information System, such as Cerner Millennium.

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F-13	13.001	The system shall be able to input, modify, inactivate, delete, update, display, and print a set of related orders to be subsequently ordered as a group on multiple occasions.	Examples of order sets include: Medications; Laboratory tests; Imaging studies; Procedures; Referrals; Etc. Does not imply that the system needs the ability to create an order set on the fly.	1						
F-13	13.004	The system shall be able to display orders placed through an order set either individually or as a group.	Need to be able to see the individual components of the order set, rather than just the name of the order set. Does not mean to break down a lab panel into individual components.	1						
F-13	13.005	The system shall allow individual items in an order set to be selected or deselected.		1						
F-14	14.004	The system shall be able to notify the relevant providers (ordering, copy to) that new results have been received electronically.	Examples of notifying the provider include but are not limited to a reference to the new result in a provider "to do" list or inbox.	1						
F-14	14.011	The system shall allow user acknowledgment of a result presentation.	This is separate from audit trail.	1						
F-14	14.020	The system shall be able to input, modify, inactivate, delete, update, display, and print clinical results received through an interface with an external source.	Implies meeting standards for client confidentiality (e.g., HIPAA) and electronic transfer protocols (e.g., HL7 based). In addition to lab and radiology reports, this might include interfaces with case/disease management programs and others. See Clinical 14.001and 14.003	1						Patient data stored within the Cerner Millennium database is not deleted.

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F-14	14.021	The system shall be able to input, modify, inactivate, delete, update, display, and print discrete lab results received through an electronic interface.	<p>Implies meeting standards for client confidentiality (e.g., HIPAA) and electronic transfer protocols (e.g., HL7 based).</p> <p>This may be an external source such as a commercial lab or through an interface with on site lab equipment.</p> <p>See Clinical 14.001and 14.003</p>	1						Patient data stored within the Cerner Millennium database is not deleted.

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<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
F-18	18.001	The system shall be able to trigger drug interaction alerts.	<p>Examples of alert reasons include: Known potential Interactions between medications to be prescribed and (current medications, allergies, client's condition as indicated by test results, past ineffectiveness of medication for client, certain types of diseases, client problem documentation, etc.); Potential interactions with current medication when new client documentation entered (e.g., client problem; client dietary information); Age (This could be based on user defined medication lists or on standard lists such as the Beers lists.); As a precautionary alert that drug interaction, allergy, and formulary checking will not be performed against the uncoded or free text medication; Drug information is outdated; Etc.</p> <p>Implies timely alerts to users, healthcare service providers, clients; Etc.</p> <p>Drug interaction alerts may be due to automated third party software database references;</p> <p>Alerts may be prioritized in system.</p> <p>Alerts reduces risk of inappropriate prescribing, prevents pharmacy call backs, and can reduce malpractice liability.</p> <p>See Practice Management 43.009, 43.010, and 4</p>	1						xxxxxxx

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F-18	18.003	The system shall be able to prescribe a medication despite alerts for interactions and/or allergies being present.	See Clinical 21.006, 22.007, Practice Management 43.009, 43.010, and 43.012.	1						
F-18	18.004	The system shall be able to input, modify, inactivate, delete, update, display, and print the severity level at which drug interaction warnings shall be displayed.		1						
F-18	18.006	The system shall be able to require documentation of at least one reason for overriding any drug-drug or drug-allergy interaction warning triggered at the time of medication ordering.	Necessary for medico-legal purposes. See Clinical 21.006, 22.007, Practice Management 43.009, 43.010, and 43.012.	1						
F-18	18.007	The system shall trigger proactive alerts, for clients on a given medication when they are due for required laboratory or other diagnostic studies, to monitor for therapeutic or adverse effects of the medication.	Limited to availability of databases. See Practice Management 43.009, 43.010, and 43.012.	1						
F-18	18.010	The system shall display, on demand, potential interactions on a client's medication list, even if a medication is not being prescribed at the time.		1						You can select a drug and then with a simple right click, you can open drug reference information and check for potential interactions.

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F-18	18.013	The system shall be able to input, modify, inactivate, delete, update, display, and print the rationale for triggering a drug interaction alert.	Drug reference information typically provided by drug database vendors is an example of the source to obtain the rationale. See Clinical 21.001, 22.001, Practice Management 43.009, 43.010, and 43.012.	1						
F-18	18.016	The system shall support accessibility of drug specific education materials from third party databases.		1						
F-18	18.019	The system shall be able to update drug interaction databases.	This includes updating or replacing the database with a current version.	1						
F-18	18.022	The system shall provide the ability to check for potential interactions between a current medication and a newly entered allergy.		1						

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F-25	25.001	The system shall be able to input, modify, inactivate, delete, update, display, print, transmit and receive electronic information between prescribers and pharmacies or other intended recipients of the medication order.	Examples of electronic information include: Initial medication order; Medication order renewals; Renewal requests and Notification of prior authorizations from or on behalf of any dispensing entity; Medication order cancellations; Etc. Until electronic standards are established, FAX is a suitable means of transmission.	1						We support all of the requirements listed other than prior authorizations and order cancellations which are not supported.
I-02	2.004	The system shall be able to order radiology tests.		1						
I-02	2.005	The system shall be able to order and schedule radiology tests.		1						
CPOE Totals:				51	3	0	0	0	0	
			54	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	

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Electronic Health Record (EHR) - Cerner Corporation

<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
F-06	6.005	The system shall provide the ability to capture history collected from external sources.	Episodes of care are based on state and local definitions. Generally, they are by periods of care at a provider, geographical, or organizational level; They may be outpatient or inpatient based and may exist concurrent with other episodes of care.	1						Cerner's Clinical Data Repository (CDR) is an enterprisewide repository of all clinical information captured on a patient as a byproduct of clinical process automation from all Cerner and non-Cerner systems in the various domains.
F-24	24.015	The system shall be able to interchange electronic clinical information between healthcare service provider systems.	Examples of sources for clinical information includes: Client registration, episodes, admissions, discharges, authorization, and service / treatments information. Implies that interchange of data will be compliant with standards (HL 7, etc.). Implies both internal and external providers.	1						
I-01	1.001	The system shall be able to receive general laboratory results (includes ability to replace preliminary results with final results and the ability to process a corrected result)	Implies compliance with HL7 and LOINC standards.	1						
I-01	1.002	The system shall be able to receive microbiology laboratory results	Organisms will be coded using SNOMED, Sensitivity testing will be coded using LOINC	1						

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Electronic Health Record (EHR) - Cerner Corporation

Req. Ctg.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
I-01	1.003	The system shall be able to respond to a query to share laboratory results	Part of ONC EHR-Lab Use Case Will work with Ambulatory Functionality Work Group to align functionality criteria and interoperability roadmap dates in preparation for next round of public comments.	1						Orders and documents to be endorsed or co-signed appear in the ordering physician's inbox. The Inbox provides the capability of forwarding documents and results to another clinician for review, as well, to sign or co-sign results.
I-01	1.004	The system shall be able to send an order for a laboratory test	Further work is need on defining the ordering messages and codes for ordering tests, should include an EHR generated order number for tracking	1						PowerOrders coordinates order management and communication across all licensed, hospital-based facilities. PowerOrders forms the basis for Cerner's computerized provider order entry (CPOE) solution.
I-01	1.005	The system shall be able to send a query to check status of a test order	Part of a function for closing the orders loop as part of quality improvement. Also need to be able to detect orders not matched with results.	1						
I-02	2.001	The system shall be able to receive imaging reports and view images, includes ECG and other images as well as radiology		1						

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<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
I-02	2.002	The system shall be able to send a query to other providers to share imaging results	See also line CCHIT IA 5.6 send a query to a registry for documents	1						
I-02	2.003	The system shall be able to respond to a query to share imaging results with other providers		1						
I-03	3.002	The system shall be able to electronically acknowledge a request for a refill sent from a pharmacy	Transaction is now wide spread use so that systems that send new prescriptions need to be ready to respond to requests for refills.	1						PharmNet Retail, our integrated retail solution (an optional offering), with our SureScripts network, that supports e-prescribing in PowerOrders, combined provide a secure, HIPAA compliant, encoded communication link to and from participating pharmacies.
I-03	3.003	The system shall send be able to a cancel prescription message to a pharmacy	Sent by the prescriber to cancel a prescription that was sent previously	1						*See Above Comment
I-03	3.004	The system shall be able to respond to a request for a prescription change from a pharmacy	Sent by the pharmacy to request that the prescriber make changes to a prescription before it is filled.	1						*See Above Comment

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Electronic Health Record (EHR) - Cerner Corporation

<i>Req. Ctg.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
I-03	3.006	The system shall be able to send a query to verify prescription drug insurance eligibility and coverage	An essential first step prior to sending a query for medication history or formulary information directed at prescription drug coverage.		1					PowerOrders supports eligibility check in during the prescribing process. With our next release Cerner will be able to support checking eligibility benefits through SureScripts, Cerner's future plan for a later release plan is to check eligibility and benefits through RxHub.
I-03	3.007	The system shall be able to access and view formulary information from pharmacy or PBM	Usually preceded by a query for insurance eligibility to verify potential source of data.		1					*See Above Comment
I-03	3.008	The system shall be able to send a query for medication history to PBM or pharmacy to access and view medication list from EHR	Part of ONC CE-PHR Use Case, used effectively during Medicare Part D pilots.		1					In our next release, we will support pulling the medication history from SureScripts in the outpatient settings. In future releases we plan to be able to pull the meds history from RxHub for outpatient settings.

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I-05	5.001	The system shall be able to register documents with document registry	The ability to register documents in a registry or a repository will be part of the NHIN and final architecture has not been selected.	1						Cerner's Clinical Data Repository (CDR) is an enterprisewide repository of all clinical information captured on a patient as a byproduct of clinical process automation from all Cerner and non-Cerner systems in the various domains.
I-05	5.002	The system shall be able to send a query to a document registry for documents.	This criterion is for the query request. This function deals only with the document registry and repository and the references to specific documents have been removed. When the criteria are finalized, any document constraints that are required by the network standards will be identified.	1						*See Above Comment
I-05	5.003	The system shall be able to send documents to repository	This criterion is for sending documents to the repository. The function of sending documents to a repository may be independent of the specific types of documents that will be identified by the network standards. Use of HITSP harmonized standards is expected and it is too early to set those standards at this time.	1						*See Above Comment
I-05	5.004	The system shall be able to respond to a query to provide a document that was previously registered in a repository	This function refers only to the ability to provide a document that has been registered in response to a query. The ability to create documents and medical summaries are discussed in other lines below.	1						*See Above Comment

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I-05	5.005	The system shall be able to create and send electronic documentation of a visit such as a consult letter to a referring physicians	Will include narrative data	1						
I-05	5.007	The system shall be able to send Medical Summary to refer or transfer clinical care of client	Used for structured data. Use of CCR will require available translation to CCD.	1						The Clinical Summary can be faxed automatically to any follow-up provider at discharge. As well, The Clinical Summary can also be sent to an Inbox if the follow-up provider has one. Additional information on CCR translation and CCHIT, in comments for Reg Nbr. 5.010.
I-05	5.008	The system shall be able to receive Medical Summary and import into EHR for consult or transfer of clinical care	May use direct communication or a regional network	1						

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I-05	5.009	The system shall be able to send data to PHR	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03	1						Cerner supports the functionality of an EHR as defined by the HL7 org. and HITSP. We intend to support the CCD as a mechanism for extraction and transmission in the CCHIT roadmap timeframe. Millennium is able to interface to any EMR/RHIO which supports the HHS adopted standards for NHIN interoperability, which were created by HITSP and used by CCHIT to certify EHR systems.

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I-05	5.010	The system shall be able to securely receive data from PHR and import into EHR	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03	1						See Comment Above; For the 2008 CCHIT criteria, we will accept the CCD (or CCR) from an external file into CAMM using the MultiMedia Manager. We will provide the user the ability to generate a CCD using the Clinical Report Request to write it to an external file.
I-06	6.002	The system shall be able to import home physiologic monitoring data from clients.	Part of AHIC Chronic Care Breakthrough, standards and implementation guides have not been selected yet	1						
I-07	7.001	The system shall be able to send client specific Public Health Disease Report for a reportable disease.	Electronic replacement for traditional reportable disease notifications to health departments, may become part of bio-surveillance in the future.	1						Cerner's PowerTrials Discovere Registries is an end user configurable platform that provides your organization the ability to develop your own registries or utilize registry content that Cerner has developed.

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I-07	7.002	The system shall be able to send anonymous utilization and laboratory bio-surveillance data to public health agencies.	ONC Bio-surveillance Use Case	1						See Comment Above
I-07	7.008	The system shall support administrative communication with registry services.	Examples of administrative communication include: Usage of registry interface and communication standards; Client identification; Retrievals of healthcare information links; payer, health plan, and client sponsor information; Employer identification; Public Health Agency identification; Healthcare resources identification; Coding, Terminology model, and Terminology verification and updates; Exchange of client data; Version control; Etc. See Practice Management 43.021.	1						See Comment Above
I-07	7.015	The system shall support standard terminologies for administrative and financial communications.	Areas of standard terminology may include: Internal and external communications; Administrative or Financial coding; Usage of explicit information models; Cross walking or deprecating different versions of standards; Updating standards information or standards protocols; Utilizing standards appropriate to effective start / end dates; Cascading terminology based on coded terminology content in clinical models (e.g., templates, and custom formularies); Terminology mapping; Standards validation; Realm specific and local profile communication; User Scope of Practice communications; Organizational Policy or law enforcement; Etc.	1						

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I-08	8.002	The system shall be able to send a query to coordinate client identification	Client identification coordination will be part of network certification scheduled to begin in 2009 and is required as part of the document transport criteria.	1						Discern Explorer is a supporting solution that uses a full-featured, fourth-generation, English-like procedural language to maintain and extract data from both Cerner Millennium™ and client-developed databases. This system provides the ability to write your own reports to coordinate any client information in the EHR.

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I-08	8.003	The system shall be able to support standard interfaces to Practice Management and Billing systems.	CCHIT requires more input on stakeholder priorities and feasibility of certifying a standard interface between all EHR systems and all practice management systems and billing systems	1						Cerner system architecture enables our applications to work together as one system. There are many benefits to this including: Eliminate charge entry when used in conjunction with our practice management solution (or appropriate interfaces to billing solutions). If a foreign system is used, we are capable of interfacing with any HL7 compliant system. Interface specifics would need to be discussed further.
I-08	8.007	The system shall be able to receive electronic authorization for referral from payer.	The system shall be able to receive electronic authorization for referral from payer.	1						
I-09	9.001	The system shall be able to respond to a query to Identify clients eligible for a clinical trial.	Clinical trial will send eligibility criteria, EHR will identify clients for review by practice and respond with a count of potentially eligible clients and an intent to participate or not participate in the trial.	1						
I-09	9.002	The system shall be able to send data to register a client in a clinical trial.	Will include informed consent	1						

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I-09	9.003	The system shall be able to receive clinical trial protocol and templates for data collection.	Will include clinical trial protocol and data collection templates	1						
I-09	9.004	The system shall be able to send a data report to a clinical trial.	Will require digital signature to assure authentication, integrity, and non-repudiation.	1						
EHR Totals:		<i>Number of Requirements</i>		34	3	0	0	0	0	
				<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	

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Personal Health Record (PHR) - Cerner Corporation

<i>Req. Ctgy.</i>	<i>Req. Nbr.</i>	<i>Requirement Description</i>	<i>DMH Comment</i>	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	<i>Vendor Comment</i>
F-06	6.014	The system shall be able to input, modify, inactivate, delete, update, display, and print information from a personal health record (PHR).		1						The patient can do these manually in the PHR (except inactivate), but this PHR data is not available in the EMR.
F-15	15.010	The system shall provide access control supporting Client authorization to import or export PHR data.	It is implied that the client (or their authorized representative) is "in control" of the client's PHR data . This includes related PHR data imports and export.						1	We do not support importing or exporting data into the EMR from the PHR.
I-03	3.011	The system shall be able to respond to a query for medication history sent by a PHR.	Part of ONC CE-PHR Use Case, may use PHR standards such as HL7/CCD and ASTM CCR instead of NCPDP standards, final standards to be specified by HITSP.						1	Medication history can be manually entered into the PHR but is not then available in the EMR.
I-04	4.003	Import immunization history from a PHR.	May be part of ONC Use Cases for 2007, represents an alternative to obtaining this data from State immunization registries.						1	Immunization history can be manually entered into the PHR but is not then available in the EMR.
I-05	5.006	The system shall be able to send information to a client for review via a personal health record (PHR).	See Practice Management 43.012.	1						
I-05	5.008	The system shall support client usage of a PHR.	Examples of support include: Providing the client a secured PHR website; Providing clients a portal to a PHR website; Etc.	1						
I-05	5.011	The system shall be able to receive registration summary from client and import into EHR.	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03						1	Registration info cannot be sent from the PHR to import into EMR.

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PHR Totals:			<i>Number of Requirements</i>	3	0	0	0	0	4	
			7	<i>Existing</i>	<i>Planned</i>	<i>Modification</i>	<i>Custom</i>	<i>3rd Party</i>	<i>Not Addressed</i>	

**CA Department of Mental Health
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Response Summary**

Company Name:	Cerner Corporation								
Product Name:	Cerner Millennium								
<i>DMH Roadmap Category</i>	<i>Nbr of Reqs.</i>	<i>Met by Existing Functionality</i>	<i>Within 12 Months</i>	<i>Requires Software Modifications</i>	<i>Requires Custom Development</i>	<i>Requires Third Party</i>	<i>Not Addressed</i>	<i>No Response</i>	<i>Invalid Response</i>
Infrastructure	96	91	0	0	0	0	5	0	0
		95%	0%	0%	0%	0%	5%	0%	0%
Practice Mgmt	162	112	26	0	4	0	20	0	0
		69%	16%	0%	2%	0%	12%	0%	0%
Clinical Data	98	97	0	0	0	0	1	0	0
		99%	0%	0%	0%	0%	1%	0%	0%
CPOE	54	51	3	0	0	0	0	0	0
		94%	6%	0%	0%	0%	0%	0%	0%
EHR	37	34	3	0	0	0	0	0	0
		92%	8%	0%	0%	0%	0%	0%	0%
PHR	7	3	0	0	0	0	4	0	0
		43%	0%	0%	0%	0%	57%	0%	0%
Total	454	388	32	0	4	0	30	0	0
		85%	7%	0%	1%	0%	7%	0%	0%