

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

Please provide the following information about your organization.	
Company Name	McKesson Corporation
Company Address	The Practice Partner product operating unit is located in Seattle, Washington McKesson Corporate Headquarters are in San Francisco, California 1 Post St.,
Company Web Site	www.McKesson.com and www.PracticePartner.com
Product Name(s)	Practice Partner Patient Records, Practice Partner Order Entry, Practice Partner Appointment Scheduler, Practice Partner Medical Billing, Practice Partner Web View, Practice Partner Zoom, Practice Partner Clearinghouse
Product Description(s)	McKesson's Practice Partner solution provides a comprehensive set of clinical and administrative tools that improve patient care while streamlining practice management for ambulatory medical practices. Practice Partner includes Patient Records—an electronic medical record system certified by CCHIT —Appointment Scheduler, a sophisticated multi-clinic
Primary Contact Name	T.J. Lynas, Senior Sales Representative, Practice Partner
Primary Contact Phone	760.728.9727
Primary Contact email	tlynas@practicepartner.com
Date of Response	5-Dec-08

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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						The access log feature records information when an operator performs the activity of printing a chart summary, a partial or complete chart, or a progress note.
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						<p>You can add notes to the patient's chart. The patient can also create "Patient Comment Notes" via the Web View portal. The patient can view these notes and other sections of the chart via Web View. A provider or administrator can log into Web View to view the patient's note. If the patient has a new comment, it is displayed on the first screen after the user logs in.</p> <p>Practice Partner users can send and receive secure messages to patients and consultants using Web View.</p> <p>In addition, you can document dispute information via scanning, dictation or manual data entry.</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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	35.003	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						Practice Partner's audit trail functionality provides this.
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						Access levels define whether an user can access a given function or type of information/chart areas, and whether the user can add, edit, view, and delete information. Individual patient charts or portions of a patient's chart can also be designated at a higher level of confidentiality. This means you can limit the availability of Practice Partner functions to a selected number of staff members. You can also specify whether a user is required to enter a password to access information.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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	35.005	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						Please see 35.005 above for information on preventing access. Regarding "breaking the glass", you can select "Access" in the "Records" category to allow the operator to access a chart that has been designated as off limits to them. This gives operators the opportunity to access a patient's chart if they have a legitimate reason. The operator's access will be recorded electronically.
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						Practice Partner will retain data until it is purged, deleted, archived, or otherwise deliberately removed.
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						You can do this via the Archive Patient Data function.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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-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						You can do this via the Restore Patient Data screen. In addition, if the information you are restoring is from a different version of Patient Records, a message will appear. Click OK to convert the archived information to the current version or click Cancel and the information won't be restored.
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						You can store scanned images for as long as they are needed. The practice can define retention periods for any system information.
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						This capability is dependent on the format and context of the information and the storage method used. Patient data that was archived can be accessed and restored in usable context.
F-36	36.007	The system shall be able to store and retrieve all the elements included in a legal health (medical) record.		1						You can modify existing templates to accommodate any specific legal requirements.
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	However, audit trail and access functionality provides protection against unauthorized activity and oversight of actions taken in the system.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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-36	36.009	The system shall be able to destroy EHR data / records so that all traces are unrecoverable.							1	This capability is dependent on the system configuration and backup/storage methods used by the practice at the practice's discretion.
F-37	37.001	The system shall be able to log exported client health information in an auditable form.		1						All chart data access (view-only or otherwise and including exports), additions, edits and deletions are recorded and auditable.
F-37	37.002	The system shall be able to log the receipt of client health information in an auditable form.		1						
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						Your system administrator can define what is tracked and recorded for the Operator Audit Trail report.
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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-38	38.002	The system shall be able to import client related health information into the system		1						Patient Records can import and load existing, saved progress note transcription, existing lab data, demographic data, and any other clinical data available in digital form. Often, many sites have saved transcribed notes in Word or Word Perfect and these historical notes can be loaded into Patient Records. Depending on the data import specifications (scope, format of data, source system) there may be a charge for data conversion services.
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	The intended destination for extracted information is not a standard capture field in the system. This information could be documented in an administrative note or designated section of the chart.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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-39	39.001	The system shall allow multiple users to interact concurrently with the EHR application.		1						Multiple users may interact concurrently and may view the same record, clinical document, or template, though the application does not allow multiple users to edit a document or piece of data at the same time.
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						Multiple users may interact concurrently and may view the same record, clinical document, or template, though the application does not allow multiple users to edit a document or piece of data at the same time.
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						Record-level protection is provided.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Infrastructure - McKesson 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-39	39.005	The system shall trigger alerts to simultaneous users of each other's presence in the same data record.		1						Multiple users can access a patient's chart at the same time (e.g., nurse entering vital signs while physician works on a progress note). Multiple users can even be in the same area of the patient's chart simultaneously (e.g., same progress note). The second user has view-only access. The system doesn't alert the users to each other's presence to avoid unnecessary workflow interruption. Only if the second user attempts to edit/change the portion of the chart will they be alerted that the other user already has that file open for editing.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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-43	43.013	The system shall support the downloading, uploading and secure connection for mobile workforce and remote users.		1						Providers can access Practice Partner applications from a remote computer located in the medical office, hospital, or home. To use Practice Partner applications remotely, you need another PC-compatible computer with a hard disk, a Windows-compatible modem, and remote access software such as pcANYWHERE, Citrix, or Microsoft Windows Terminal Server. So equipped, you then use the remote access software to log on as usual to your network, Windows, and Practice Partner applications. The screen on the remote computer will look exactly as it does when you are running Practice Partner applications directly. You also use the same keys to perform tasks. Response time is relative to connectivity.
F-43	43.038	The system shall be scalable to meet current and future user access and data storage needs.		1						The current architecture of Practice Partner applications can support thousands of concurrent users and can expand to virtually any-size organization.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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-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						Practice Partner applications have an intuitive, Microsoft Windows-based user interface that is easy to learn and easy to use, incorporating familiar drop-down menus, a mouse, etc. The patient's record is designed to look like a paper "chart," facilitating easy access to information.
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						Patient information can be entered via data entry, transcription, voice recognition software, touch screen methods, electronic interface, and more.
F-43	43.041	The system shall support remote system monitoring technology.							1	However, Technical Support uses a sophisticated remote diagnostics tool to access your system for troubleshooting.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Infrastructure - McKesson 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-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						Remote access is controlled in the same way system access is controlled: through the use of unique user IDs and passwords. Access levels can be set by the administrator at both the group and individual level.
F-43	43.048	The system shall support and implement redundancy / fault tolerance for 100% system availability.							1	System uptime generally depends on a practice's hardware and network configuration.
F-43	43.049	The system shall support secure Web-based system access.		1						This is available via remote access capabilities combined with our software privacy and security features.
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						Practice Partner supports management of both structured and unstructured health record information.
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						Data (both free text and discrete data) are linked to the patient and are cross-linked within the system.
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						You can limit the availability of Practice Partner functions and data to defined staff roles.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Infrastructure - McKesson Corporation

Req. Ctg.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
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						You can do this through Practice Partner's access control functionality.
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						You can do this through Practice Partner's access control functionality.
S-01	1.019	The system shall require user login passwords be changed regularly.		1						An operator-created personal password may be set to expire after a set period of time.
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						
S-01	1.022	The system shall require valid and secure user login passwords structured.		1						The system administrator can define requirements for passwords (e.g., number of characters, use of numerals, symbols, etc.)
S-01	1.023	The system shall provide the ability to automatically log users out of the system after a period of inactivity.		1						You can set up a workstation and Practice Partner to park and/or lock after a designated period of inactivity with the autopark feature.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
S-01	1.024	The system shall comply with client confidentiality and privacy.		1						The system's security features and capabilities support the practice in complying with confidentiality and privacy processes and rules. While software technically cannot be "HIPAA compliant," a system can support HIPAA-compliant data security and practices, as Practice Partner does fully.
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						Certain patient information (at the patient record or individual data screen level) can be defined as confidential, requiring entry of an authorized user password for access, restricting access to only specific users.
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						You can select Access in the Records category to allow the operator to access a chart that has been designated as off limits to them. This gives operators the opportunity to access a patient's chart if they have a legitimate reason. The operator's access will be recorded electronically.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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	Although, the operator's access is recorded electronically, access is not set up to require the provider to document and record the reason(s) for requesting access. The system administrator would need to log this information separately.
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						Each user must log on when accessing the application from any type of networked or remote. You can define roles and levels to designate user access to PHI.
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						A system administrator may limit the number of log on attempts. If an operator's number of unsuccessful attempts exceeds the number permitted, the operator's status changes to inactive and Patient Records must be restarted. A system administrator must restore an inactivated operator to active status.
S-02	2.005	The system shall provide an administrative function that resets passwords.		1						A system administrator must restore an inactivated operator to active status.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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						When an operator uses a temporary password created by a system administrator during log on, "Password" displays after using the temporary password. The operator then uses "Password" to create an ongoing personal password.
S-02	2.007	The system shall provide only limited feedback information to the user during login authentication.		1						Operators can be assigned a default provider and practice that display automatically on the log on screen. Otherwise, only the entry fields for user ID and password appear during authentication.
S-02	2.008	The system shall support case-insensitive usernames that contain typeable alpha-numeric characters in support of ISO-646 / ECMA-6 (aka US ASCII).		1						The system supports case-insensitive usernames in support of ISO-646 / ECMA-6 (aka US ASCII).
S-02	2.009	The system shall allow an authenticated user to change their password consistent with password strength rules.		1						The system administrator can define requirements for passwords (e.g., number of characters, use of numerals, symbols, etc.)

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
S-02	2.010	The system shall support case-sensitive passwords that contain typeable alpha-numeric characters in support of ISO-646 / ECMA-6 (aka US ASCII).		1						The systems supports case-sensitive passwords that contain typeable alphan-numeric characters in support of ISO-646 / ECMA-6 (aka US ASCII).
S-02	2.011	The system shall not store passwords in plain text.		1						Passwords are stored in encrypted format
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						The system administrator may optionally prohibit a new password matching a recently used password. This may be set to prohibit matching up to the last five passwords used.
S-02	2.015	The system shall provide the ability to implement Chain of Trust agreements.							1	
S-02	2.016	The system shall support, at a minimum, two-factor authentication in alignment with NIST 800-63 Level 3 Authentication.							1	
S-02	2.017	The system shall not export passwords in plain text.		1						Passwords are stored in encrypted format
S-02	2.018	The system shall not display passwords while being entered.		1						Only asterisks (*) display in the password entry box in order to protect the security of the password.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Infrastructure - McKesson 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>
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						Onsite training is supplemented by phone assistance from the trainer as well as recorded training classes and detailed documentation.
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						Practice Partner application data is encrypted at the transmission point using triple DES. Secure data interfaces are supported via Certificate authentication, SSL encryption and VPN (usually triple DES).
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						Practice Partner application data is encrypted at the transmission point using triple DES. Secure data interfaces are supported via Certificate authentication, SSL encryption and VPN (usually triple DES).

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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					We only support data communication using IPSEC for the creation of a VPN. SSL may be used for transferring files over FTP (batch interfaces). TLS will be supported next year for the purposes of communicating data via IHE Profiles (XDS, Cross Document Sharing).
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					SSL may be used for transferring files over FTP (batch interfaces). TLS will be supported next year for the purposes of communicating data via IHE Profiles (XDS, Cross Document Sharing).
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	We do have features such as chart exporting, patient inquiry and exporting to PDA that allow the exporting of data on to PDA, CD-Rom, etc but we do not encrypt the exported data other than if the data already is encrypted it remains encrypted.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Infrastructure - McKesson 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>
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	This would be a function of the security of the wireless network, not addressed within the application itself.
S-04	4.009	The system shall provide the ability to obfuscate (intentionally make difficult to read) data.							1	
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						You can do this by setting the appropriate access levels for different types of activities in the system.
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	We do have features such as chart exporting, patient inquiry and exporting to PDA that allow the exporting of data on to PDA, CD-Rom, etc but we do not encrypt the exported data other than if the data already is encrypted it remains encrypted.
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	The system does not provide a warning. User id and password are required to proceed past the initial login screen.
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	

**CA Department of Mental Health
BH-EHR Requirements Survey**

Infrastructure - McKesson 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>
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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	Not all events listed are recorded. However, all chart data access, additions, edits, and deletions are recorded and auditable. Patient Records incorporates audit trails of each access to specific data and for all system transactions including look-ups of patient data. The system also records all successful and unsuccessful login attempts. Full audit capabilities are included as part of the Practice Partner system and do not need to be purchased as an add-on product.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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						When you configure Practice Partner to track access to individual patients, each time an operator opens and closes a patient chart, the following information is recorded: <ul style="list-style-type: none"> • Internal patient ID • Internal operator ID • Date chart was opened • Time chart was opened • Date chart was closed • Time chart was closed • External patient ID • External operator ID • Operator's Access Level • Provider ID • Type of Access: Chart, Export, or Print • Application logins/login attempts
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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						Your systems administrator determines access levels. While the action of purging the access log utility is not audited, the main audit trail cannot be purged.
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	
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	Practice Partner applications do not have an internal backup mechanism. Backups are typically performed as part of standard server maintenance procedures.
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	Practice Partner applications do not have an internal backup mechanism. Backups are typically performed as part of standard server maintenance procedures.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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			McKesson does not provide hardware as a part of the Practice Partner system. Typically, the ability to do backups in a live environment requires some expensive system architecture that may be cost prohibitive. Practice Partner will be happy to discuss DMH's needs for system uptime and make recommendations for hardware and network configurations prior to purchase.
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						System and database backup procedures are typically specified by each customer in accordance with their hardware and network configuration management.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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	McKesson does not typically sell or support hardware in conjunction with the Practice Partner system, nor do we provide site preparation or hardware set up services; however, we will fully support DMH in the process and will coordinate with internal and third-party IT and support staff during set up to help ensure compatibility between our software and the site's network and hardware configuration, and anti-virus/firewall software. We can also refer you to several installation and support organizations that work with Practice Partner on a regular basis.
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	Please see 7.001 above.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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: HL-7, HTTP, FTP; etc. This information may be used by the healthcare facility to configure their network defenses (firewalls and routers).	1						Please see 7.001 above.
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						We provide an Installation Guide
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						New Practice Partner features are provided through a formal upgrade process, using an upgrade installer program provided by Practice Partner. Patches are produced only on occasion and supplied directly to customers, generally on CD-ROM. McKesson does not typically support operating systems or underlying tools in conjunction with the Practice Partner system.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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						Our user and technical guides provide this information.
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						Complete specifications and recommendations for hardware, network and workstation configurations are provided in the attached Practice Partner System Requirements Guide. Your Practice Partner Project Manager will coordinate with DMH and our technical experts will make recommendations for a system configuration to support your needs for capacity and performance.
S-07	7.008	The system shall include documented procedures for product installation, start-up and / or connection.		1						The Practice Partner Installation Guide provides detailed instructions on installing or upgrading Practice Partner.
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	

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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						The installation media (CD-ROMs) for Practice Partner software have been subject to scanning for viruses with McAfee Virus Scan using up-to-date virus detection data files.
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	Practice Partner provides applications only. Hardware configurations and applicable system performance metrics are managed by the client. Our technical experts will recommend a system configuration that will support DMH's needs for system performance and capacity.

CA Department of Mental Health
BH-EHR Requirements Survey

Infrastructure - McKesson 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>
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	This will depend on the hardware configuration chosen by each DMH agency. Please note that we provide detailed backup and recovery recommendation in our technical guides.
Infrastructure Totals:			<i>Total Number of Requirements</i>	70	2	0	1	0	23	
			96	<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
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						Practice Partner is not designed as a true Master Patient Index (MPI) system, but can capture, store and generate reports based on MPIs from other systems. Responses here refer to the Client Record capabilities of the Practice Partner application, which does create and maintain one master record (chart) for each patient.
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						Refer to the comment in item F-01, 1.001
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						Refer to the comment in item F-01, 1.001

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-01	1.005	The system shall use key identifying information to identify (look up) the unique Master Client Record.		1						Refer to the comment in item F-01, 1.001
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						Refer to the comment in item F-01, 1.001
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						Refer to the comment in item F-01, 1.001
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						Refer to the comment in item F-01, 1.001.

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-01	1.011	The system shall be able to integrate client records with information from other databases or EHR computer systems (internal or external).	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). Examples of Call-Logging Data Include: Date of call, staff receiving call, name, telephone number, language requirement, referring party, and call disposition.	1						Practice Partner supports inbound and outbound standard and custom interfaces using industry-accepted data formats such as HL7, ASTM/CCR, NCPDP Script, X12 (HIPAA), and XML.
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						Additional client classifications can be incorporated as custom (reportable) date fields.
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						Checking for duplicate names. System will alert user when entering a duplicate patient ID number or name.
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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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						<p>The Practice Partner system can allow users to input, modify, inactivate, delete, or update complete demographic and clinical data for a patient, and the system can capture, display print or export a complete patient chart, partial chart, or chart summary, including export in CCR format. Demographic information can be input in free text, drop-down menu, and autofill (e.g., zip code). Clinical information can be input in free text, via progress note templates, pick lists, transcription, voice command (using Dragon), or touch screen.</p>
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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	
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	User must recreate mistakenly merged records.
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						Certain minimal fields are required to create a record: patient ID#, first name, last name, and designated provider/practice.
F-02	2.014	The system shall be able to capture limited pre-registration information when full registration cannot be completed.		1						Certain minimal fields are required to create a record: patient ID#, first name, last name, and designated provider/practice.
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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-02	2.019	The system shall allow clients to input data.	<p>Example data includes: demographic, insurance information, family history, social history and prior medical history.</p> <p>Such data entry may occur via Internet Web interfaces, an in-office kiosk, etc..</p>	1						The Practice Partner Web View portal allows patients to pre-register, enter history and insurance information, request appointments, and email with physicians.
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						Hardcopy authorizations can be scanned or imported as electronic files, saved in a designated section of the patient's chart, and the system can record that authorizations/ consents have been obtained
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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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						Can be recorded as non-structured data (attached image file of signed document) or discrete data (data field set up to record presence of an order).
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						Can set up a discrete data field to record the date last reviewed
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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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						
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	Practice Partner is not designed as a credentialing maintenance system. A list of providers and information about them (including credentials and dates) can be stored in the system, but does not automatically validate credentials at the point of service.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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						
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, insura</p> <p>Scheduler data may be populated either through data ex</p>	1						Practice Partner Appointment Scheduler provides all of these capabilities, as well as built-in wait list capability, access to billing and copay information, reminders for any overdue health maintenance screenings, and real-time eligibility checking.

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						Email, letter, notice, and phone message script templates can be created in multiple languages to use for different patient populations. The system does NOT provide auto telephone messages or auto-email. The system does provide automatic dialing of a patient's number if connected to a phone/fax modem, and when initiated by a user.
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						
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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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						<p>Scheduler and Patient Records reports can be generated easily in the system by selecting from a drop-down menu. The system also provides ad hoc reporting tool called Patient Inquiry with which a user can create custom queries based on virtually any discrete clinical, demographic, or service data field in the system.</p> <p>Practice Partner applications are also ODBC compliant, Practice Partner applications are ODBC compliant, allowing clients to directly query the database to create custom reports using third-party tools. We provide a data dictionary to customers to support this function.</p> <p>The Health Maintenance feature provides complete tracking and management capabilities for a complete range of clinical items including the entire U.S. Preventive Services Task</p>

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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						Refer to the comment in item F-28, 28.001
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						PDF files can be uploaded as file attachments only.
F-28	28.007	The system shall be able to save report parameters for generating subsequent reports.		1						Patient Inquiry query paramaters can be saved for later use.
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						Via PPRNet
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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				Generated reports can be stored in any location specified by the practice on the workstation, network, or server. Reports can be given a name as they are saved. Opening a previous report from it's stored location offers the user an option to re-run/update the report.
F-28	28.016	The system shall support the collection, compilation, reporting and analysis of all mandated outcomes.		1						

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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		Depending on the specific measures, they can be reported via standard reports, Patient Inquiry queries, or using third-party reproting tools such as Crystal Reports. Analysis capabilities in the Practice Partner system consist only of a statistical summary. Additional analysis can be provided by third-party tools. PPRNet also provides benchmarking quality reports, including reports on individual patient outliers.
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		Analysis capabilities within the Practice Partner system consist only of a statistical summary. Additional analysis can be provided by third-party tools. PPRNet also provides benchmarking quality reports, including reports on individual patient outliers.

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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		Reporting capabilities are provided by the system. Analysis capabilities within Practice Partner consist only of a statistical summary. Additional analysis can be provided by third-party tools. PPRNet also provides benchmarking quality reports, including reports on individual patient outliers.
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	System performance monitoring would be a function of the server or network on which the Practice Partner applications reside.
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						Practice Partner supports ANI SQL with either Oracle or MS SQL Server. ANI SQL is not supported with c-tree, except with the c-tree SQL Server version.
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						Practice Partner includes archive and restore capabilities.
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		Database documentation would be provided as a feature of the backend database product selected by the customer. Practice Partner database choices are: Practice Partner database choices are FairCom c-tree Server, Microsoft SQL Server or Oracle.
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						Medical Billing (PMS) reports provide drill-down capability. Patient Records (EMR) reports do not currently.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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		Practice Partner software does not provide views to the database beyond the primary view. This can be accessed via ODBC.
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						
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						Depending on the specific data and formats required, the need to develop customized interfaces, etc. May involve an additional fee.
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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-28	28.038	The system shall be adaptable to specification changes from payors, and other business associates.		1						Depending on the specific changes required, and the impact on existing interfaces, need to develop customized interfaces, etc. May involve an additional fee.
F-28	28.039	The system shall support client satisfaction surveys reporting.	Implies scheduled and on-demand surveys.			1				Survey responses can be collected via the Web View portal, and then exported to a third party data tool for analysis.
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	The system can validate specific data entry parameters (e.g., numeric entry required in a data field), but does not provide validation beyond that.
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.	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						

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						<p>The built-in Practice Partner E&M coding engine suggests a coding level using recent coding guidelines. If physicians do not agree with the suggestion, they can use the coding wizard to supplement the information included in the note (history result, physical examination result, medical decision making complexity). Once physicians select the appropriate code, the procedure code is automatically inserted into the saved note and populates the electronic encounter form that Patient Records creates for the visit.</p> <p>Patient Records includes a subscription to CPT/ICD-9 code databases, with annual updates.</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-31	31.004	The system shall provide the ability to interface the most current procedure code with the current service/Care Plan.		1						
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						
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						
F-31	31.010	The system shall support financial and administrative rules that ensure actual payor charges match the clinical charting.		1						
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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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.	<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						The Practice Partner Clearinghouse service (powered by RelayHealth) provides real-time eligibility checking.
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						Via the Practice Partner Clearinghouse
F-32	32.007	The system shall support Medi-Cal eligibility evaluation of registered clients..	<p>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.</p> <p>Evaluation may be ad hoc or scheduled daily, weekly, monthly, etc.</p>						1	The system can capture and report on information in standard or user-customized data fields, but no eligibiliy evaluation capability is provided by the system.

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						
F-32	32.015	The system shall integrate Medi-Cal eligibility assessments processes with eligibility referral systems.							1	The system can perform real-time eligibility checking, interfacing with external eligibility referral systems that are part of the RelayHealth network.
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						Assuming the data required is already captured in the system, or is set up by the practice as custom, discrete data fields, then the Patient Inquiry ad hoc query tool can generate reports. Alternatively, third party tools such as Crystal Reports can be used to query the database directly.

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						The Form Layout tool can be used to create and store a wide range of form templates. When a user generates a form, fields in the template will automatically populate with the necessary patient-specific data.
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						Refer to the comment in item F-32, 32.019
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						
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						
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						Assuming the data required is already is captured in the system, or is set up by the practice as custom, discrete data fields, then it can be input, modified, deleted, updated, displayed, copied and printed. The Patient Inquiry ad hoc query tool can generate reports. Alternatively, third party tools such as Crystal Reports can be used to query the database directly.
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			Would involve custom interface/impor services for an additional fee.
F-40	40.004	The system shall be able to produce reports based on absence of mandated data elements.						1		Using third-party reporting tools to query the database (ODBC)
F-40	40.006	The system shall be able to generate error or suspension reports prior to submission of a mandated report.							1	

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						Assuming the data required is already is captured in the system, or is set up by the practice as custom, discrete data fields, then it can be input, modified, deleted, updated, displayed, copied and printed. The ad hoc query tool can generate reports. Alternatively, third party tools such as Crystal Reports can be used to query the database directly.
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	
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	

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						Practice Partner allows users to create forms and documents in the system that will autopopulate with patient-specific information. Further definition of a "Treatment Authorization Request" is needed, but Practice Partner can likely accomodate this requirement, assuming a TAR can be set up as a form template or run as a report via the system query tools. Note that Practice Partner is designed to support ambulatory practices, not inpatient care.

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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	Practice Partner is not designed as an inpatient system, does not generate utilization review notes (although such notes can be captured as attachments to the patient's record, or imported as text documents using the Text Data Loader), and does not handle daily census and bed statistics data. The system can allow users to input, modify, inactivate, delete, update, display, copy, and print client care episodic data for AMBULATORY care.
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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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	The system can print EOB information, generate user-defined letters; capture, generate and report on a broad range of medical billing activities. However, Practice Partner is not designed to perform claims adjudication.
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						
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						Refer to the attached Product Bulletins on Practice Partner Electronic Payment and Remittance Advice
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 Medical, Medicare, Insurance, and other providers (such as other Counties).	1						Via the Practice Partner Clearinghouse. Refer to the attached Product Bulletin for details.

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-41	41.007	The system shall be able to pend claims for review and subsequent approval or denial.		1						
F-41	41.008	The system shall be able to integrate with an accounts payable system that supports EHR related claiming.					1			Depending on the specifications of the Accounts Payable system, interface capabilities required, data formats, etc. This would incur additional fees for the creation and maintenance of a custom interface.
F-41	41.010	The system shall be able to input, modify, deactivate, 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						
F-41	41.011	The system shall be able to input, modify, deactivate, 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						
F-41	41.012	The system shall be able to input, modify, deactivate, delete, update, copy, and print payment and denial information from providers related to coordination of benefits.		1						
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						
F-41	41.016	The system shall be able to generate required Internal Revenue Service (IRS) Form 1099 documents each calendar year end.							1	The system can generate via A/R reporting the necessary dollar amounts to report, but not the forms themselves.
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	The system can track and generate reporting to identify the accounts requiring adjustments, the checks cannot be cut from the system.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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 a</p>	1						

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-42	42.002	The system shall be able to transmit and receive A/R health claims information.	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.	1						Practice Partner fully supports EDI 835 and 837 formats, for accounts receivable, not accounts payable. Benefit and spend down as well as UMDAP information can be captured and billed appropriately.
F-42	42.003	The system shall provide accounts receivable support for cost reporting requirements.	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. Examples of Required Reporting: DMH EOY Cost Reporting, CSI & OSHPD, MHSA, PATH, and SAMHSA Reporting.	1						The system supports charge and payment formulas, identification of procedures that are billed either to a separate entity or under a different formula and payor specific contracts can be loaded to aid in identifying specific reimbursement expected from the payor.
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						Via the Clearinghouse, powered by RelayHealth

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-42	42.009	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all required A/R business rules.	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	1						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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	
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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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						
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						
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						Any account or line item can be set to a hold status for statement printing.
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						
F-42	42.032	The system shall be able to place messages in client billing statements.	<p>Examples are: Culturally appropriate billing warnings, payment thank-you messages, and healthcare service provider messages.</p>	1						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-42	42.034	The system shall be able to display and print an audit trail of client billing invoices and statements.		1						
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						The system auto prompts for receipts when front end money is collected.
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						
F-42	42.051	The system shall support that outstanding charges remain as an open receivable until paid or adjusted.		1						
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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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 inactiviity; Overdue payment report; Payor Denial reports, Non-Sufficient Fund payment reports; Capitated Funded Clients listing; and Daily transaction log report.</p>	1						
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						
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						The system allows the end user to identify and create statement and 'bill to' rules for individual charge items or for the patient/guarantor account as a whole.
F-42	42.107	The system shall support compliance with Generally Accepted Accounting Principles (GAAP).		1						
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						The end user can create formulas within the program to prevent and or alert users to A/R data inconsistencies.
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						Yes, Zip Code. Bar coding to the extent supported by RelayHealth.
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						
F-42	42.125	The system shall generate collection letters.	Implies ability to create / use collection letter templates.	1						

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						Practice Partner applications (Medical Billing, Appointment Scheduler and Patient Records) are fully integrated, and use the same database. Information such as patient address updated in one application will update the database and be immediately accessible by the other applications.
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						
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	

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						It is likely that Practice Partner could support DMH's needs in this area with Health Maintenance, since you can trigger HM when a problem is added (i.e. you'd link certain problem codes that represent critical incidents to HM Templates that would include a HM procedure that represents the act of reporting the incident; alternatively you could run reports for those problem codes).
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						Appointment Scheduler provides extensive schedule management capabilities. All Practice Partner applications incorporate an internal messaging system, personal task list, and ability to assign tasks to other users.

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						Information can be stored in and easily accessed from the Patient Records Online Knowledgebase. The Knowledgebase can act as a practice "intranet."

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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 da</p>	1						

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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</p>	1						
F-43	43.010	The system shall be able to enforce all Workflow Business Rules.							1	

Workflow rules can be stored in the Knowledgebase

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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						
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					
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						This information can be stored in the Knowledgebase

CA Department of Mental Health
BH-EHR Requirements Survey

Practice Management - McKesson 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-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						
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	
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			Creating electronic interfaces to transmit information (in real-time or batch mode, one-way or bi-directional) is well within the capabilities of the Practice Partner interface team. Set up and maintenance of interfaces will incur an additional fee.
F-43	43.028	The system shall ensure that workflows are compliant with federal, state, and local laws, rules, and regulations.							1	

**CA Department of Mental Health
BH-EHR Requirements Survey**

Practice Management - McKesson 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-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	Practice Partner is designed as in outpatient/ambulatory system, and does not support inpatient care.
F-43	43.035	The system shall support single sign-on software products.	Implies maintaining internal security controls.						1	Users must sign on directly to the Practice Partner application; this maintains an additional level of authentication/ verification for enhanced security.
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						Depending on the mode of populating the data (e.g., loading of historical EHR data) there may be an additional fee for interface or data conversion services.
Practice Management Totals:			<i>Number of Requirements</i>	##	1	2	3	6	23	

CA Department of Mental Health
 BH-EHR Requirements Survey

Practice Management - McKesson 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>
			162	<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
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						<p>Patient Records is a complete EHR system featuring a progress note editor, problem lists, vital signs, health maintenance, Rx writer, labs, flow charts, images, workflow tools, and more.</p> <p>In Patient Records, codes from any coding system, such as ICD-9-CM or SNOMED-CT can be associated with a problem.</p> <p>Practice Partner uses an intuitive Microsoft Windows graphical user interface that incorporates icons, pull-down menus, and a mouse. Patient Records looks like a chart, has a progress note centric design, and is easy to learn and easy to use.</p>

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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						Problem List functionality in Practic Partner is extensive, providing a longitudinal record of the problems for which the patient has sought or received care
F-03	3.005	The system shall be able to record the user ID and date of all updates to documented client problems.		1						Audit log function
F-03	3.006	The system shall be able to associate orders, medications, and care documentation (e.g., notes) with one or more problems.	Implies ability to associate a visit with a particular diagnosis / problem. Association may be in a structured or non-structured data format.	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	
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						In Patient Records, codes from any coding system, such as ICD-9-CM or SNOMED-CT can be associated with a problem.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-03	3.016	The system shall be able to manually order a problem list.		1						Patient Records automatically assigns numbers to the problems in the Major Problem list and displays Major Problems in the order of their assigned number. By editing these numbers, users may control the order in which Major Problems are listed on the Problems/Procedures screen.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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	4.001	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						<p>Each patient chart has its own medication list. You can include medications prescribed by any provider.</p> <p>Information in this list includes the following details for current medications:</p> <ul style="list-style-type: none"> • Medication name • Size • Dosage • Frequency <p>You can add user-defined fields and comments as needed. You can use access level controls and template customization to store data in discrete fields.</p> <p>You can view and print medication lists in a number of different formats.</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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	4.002	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						User-defined data fields could be added to capture this information.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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	4.003	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> <p>Display and printing of information may be controlled through</p> <p>It is important to have all current medications in the system</p> <p>Allowing entry of free text medications (e.g., blue hyper</p> <p>See Practice Management 43.006 and Infrastructure 43</p>	1						<p>You can access and control medication-related information with Patient Records. You can include client prescriptions, prescribed medications and non-prescribed medications. You can include medication name, schedule, quantity, dosage, order date, date last taken, side effects and effectiveness and more. Patient Records supports NDC, or users can enter both free text and uncoded medications. The system keeps current, historical, and ineffective medications lists for each patient. Full prescription writing capabilities include checking for drug interactions, allergies, drug dosage, and drug disease interactions, with feedback on drug costs, insurance formularies, alternative drugs, and drugs by indication. More than 1,000 Rx templates are included with unlimited additions and provider-specific templates. Medication information is stored in discrete data fields. You can add user-defined</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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	4.005	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						Patient Records includes provider dashboards, and an electronic inbox to view, sign, and route all results (e.g. labs and reports) from both internal and external sources.
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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	4.013	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						The prescription writer in Patient Records includes the ability to list separately ineffective medications, historical (completed or discontinued), or delete medications. They system documents the operator activity through the audit trail functionality. Reason for change could be documented in a note.
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	

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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	4.026	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication information in any medication formulary list.	<p>Examples of lists include: Medication formulary for entire organization; Medication formulary defined by client classification, funding, Scope of Practice, Etc.</p> <p>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..</p>	1						You can print, copy, update display, modify, input and inactivate the formularies for insurance carriers. You can also print the general formularies for a specific provider or for a group or specialty. If you want to see both insurance and general formularies, you can print them as well. Practice Partner also offers real-time formulary checking with the ePrescribe feature, powered by SureScripts and RxHub.
F-04	4.027	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication formulary rules and guidelines.	<p>Examples of rules include: List access; Formulary usage is optional or required criteria; Effective stop / start dates of formulary usage; Etc.</p> <p>Guidelines may be reference documents.</p>	1						

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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	4.028	The system shall include access to the National Drug Code (NDC) database.		1						NDC codes can be associated with prescriptions in the system, however, the medication master list in Practice Partner is not NDC-based because NDC specifies drugs at a level of specificity finer than what is of concern to the prescribing physician in most instances (i.e., NDC is specific to manufacturer, packaging, etc.). Our medication master list is based on a proprietary Medispan code (Drug Descriptor Identifier, or "DDI") which identifies medications at the prescribable level (medication name, strength, and dosage form, e.g. "Prozac 10mg Tablet").

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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	4.029	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						You can create, customize, print, modify, copy (and so forth) prescription templates as needed.
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						Progress note templates and Health Maintenance templates can prompt and support the physician in monitoring, scheduling and supporting client involvement in a Physician Assistance Program.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						<p>There is specific portion of the patient chart where allergies and intolerances are documented. If a user has difficulty spelling a particular allergy, there is a look-up and cross-reference feature that runs an auto-check to ensure that the correct allergy is recognized by the system. The allergy record stores both the allergy name (agent), as well as the type (classified drug allergy, drug intolerance, food allergy, or other), severity (severe, moderate or mild), reaction (e.g., shock, asthma, rash), and code.</p> <p>Whenever a new medication prescription is created, the system will automatically check for any relevant allergies or intolerances, drug interactions, family history risks, or social history (e.g., alcohol use), assuming the practice maintains a subscription to the drug database. This database is available on a subscription basis to all Patient Records</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						The system requires acknowledgement of any allergy/interaction alerts. You can use the system's audit trail functionality to review access to and changes to allergy information, including time stamps.
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						You can set up "No Known Drug Allergies" as a user-defined field or note in the comments field of the patient's medication list. Please note that the nkda (no known drug allergies) abbreviation is ignored when performing drug interaction and allergy checking.
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						Please see 5.011 above.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-05	5.015	The system shall be able to check for potential interactions between a current medication and a newly entered allergy.		1						When you enter a new prescription or allergy, the system can check for interactions.
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						We currently work with Medi-Span, part of Wolters Kluwer Health Drug to provide allergy interaction checking.
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						When entering intolerances, options include Drug Allergy, Drug Intolerance, Miscellaneous, and Food Allergy.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson Corporation

Req. Ctg.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
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						<p>You can view, modify and print a chart summary, a partial or complete chart, a medical summary, notes, immunization reports, prescription log reports, access log reports and more.</p> <p>You can monitor actions taken on information via the system's audit trail and access log functionality.</p> <p>The system stores lists for major problems, episodic problems, and diagnoses.</p>
F-06	6.002	The system shall capture client history information in a structured data format.		1						Practice Partner supports management of both structured and unstructured health record information.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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						Please see 6.001 above.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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 all healthcare service provider documentation in system.</p> <p>Input may be by client and provider.</p> <p>Examples of display include: Filtered / sorted by various criteria</p> <p>Conversion of information to numeric values that can be used in reports</p> <p>See Practice Management 43.006 and Infrastructure 43.006</p>	1						<p>The system can input, modify, inactivate, delete, update, display, copy and print all healthcare service provider documentation in the system. The patient chart captures, stores, and integrates a comprehensive set of document on the patient including vital signs, problems/diagnoses, medications and allergies, lab tests, progress notes, medical/social/family history, care plans and health maintenance items, assessment results, and more. The system provides flow charts and graphing capabilities to monitor patient progress. You can customize progress note templates and create custom data fields and free text notes to support the capture of virtually any information.</p> <p>You can view, modify and print assessments, notes, progress note, wellness plans access log reports and more. You can monitor actions taken on information via the system's</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						Note that all Practice Partner applications access a single, integrated database.
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. Subsequent actions will not destroy any of the original finalized documentation, i.e., strikeouts, addendums, etc., will be used instead of text destruction.		1						A partially completed note can be saved for later completion. Practice Partner keeps track of changes made to the text-based sections of the patient chart, including Progress Notes. You can compare up to five revised versions of the same note against previous versions. When a note is completed the provider "signs" it via electronic PIN. The administrator can print a report of all unsigned notes.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-08	8.007	The system shall support electronic signatures and co-signatures in documentation.	See Practice Management 43.006 and Infrastructure 43.040	1						You can require electronic signatures from providers on notes, prescriptions and results and allow one or more electronic signatures.
F-08	8.008	The system shall be able to addend to documentation that has been finalized.		1						
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						Practice Partner keeps track of changes made to the text-based sections of the patient chart, including Progress Notes. You can compare up to five revised versions of the same note against previous versions.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						Patient Records provides access to a wide variety of historical and current results for graphing and trending using flow charts including all laboratory data, vital signs, other numeric data, medications with dosages, and prenatal data. The vital signs section of the chart provides growth charts for children and percentiles. You can use the system to calculate and graph BMI and more.
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						You can plot and compare weight, height and BMI for age and sex over time with Practice Partner.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						The normal ranges that you define on the Laboratory Value Ranges screen determine which values are highlighted as abnormal on the Laboratory Data screen for lab data entered directly. Abnormal results are highlighted in color (red for higher than defined normal range, green for lower than defined normal range).
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						Patient Records currently supports ICD-9-CM, ICD-10, CPT, ICHPC, LOINC, NDC, and SNOMED-CT.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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.	<p>Examples of templates include: Structured progress notes; Intake assessments such as the mini mental health exam; Care Plans; Wellness and Recovery Plans; Etc.</p> <p>User ability to customize templates is preferred.</p> <p>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.</p>	1						<p>Patient Records includes nearly 200 progress note templates to assist in documentation. You can input, modify, inactivate these templates, and so forth.</p> <p>Templates support structured/codified data. Patient Records can automatically suggest an E&M code based on the information entered in the progress note. All of Patient Record's customizable progress note templates include E&M codes. If physicians modify an existing template or create a new one, they can add E&M coding labels so that Patient Records can suggest a coding level when the note is saved.</p> <p>When the note is saved, the E&M coding engine suggests a coding level using recent coding guidelines. If physicians do not agree with the suggestion, they can use the coding wizard to supplement the information included in the note (history</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						Client annotations can be incorporated via free text notes or scanned paper documents.
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						Client annotations can be saved in a designated section (tab) of the patient chart.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						You can have clients (patients) enter health information online via WebView during registration, such as demographics, and medical, family and social history. The information automatically populates the patient's chart and other relevant areas of the system.
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						You can customize templates for specialized types of activity such as a group visit.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						The Practice Partner Knowledge Base comes pre-loaded with clinical guidelines and care plans from the Agency for Health Care Policy and Research and the US Preventive Services Task Force. Many practices store other decision support files in the Knowledge Base or link to information available on the Web. Using Patient Record's progress note templates, you can build links that access knowledge base documents or Web pages. This provides decision support at the point of care, when it's needed.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						You can track patients through each stage of their visit, including time in process. In addition, Appointment Scheduler Enterprise has multi-clinic capabilities.
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						Using the Merge Patients utility, you can combine patient information from two, separate records. You can also move or merge problems between the Major Problems list, Other Problems list, Diagnoses list, Risks list, and Hospitalizations list.
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						You can open and display multiple screens and multiple patient charts at the same time.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-08	8.049	The system shall require user confirmation prior to merging any client healthcare service documentation.		1						The Practice Partner Sign In screen appears when you choose Merge Patients. You will need to enter a valid password in order to merge records.
F-08	8.050	The system shall be able to recreate as separate documentation records previously merged client healthcare service provider documentation.							1	Once merged the records cannot be automatically unmerged.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-08	8.064	The system shall support healthcare service provider Report Dictation.	<p>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.</p> <p>Also supported by 8.001 and Infrastructure 43.040</p>	1						<p>Patient Records has flexible data entry methods to suit different physician styles including: keyboard, speech recognition (integrated with Dragon NaturallySpeaking for both data entry and commands), touch screen, handwriting recognition, and dictation. You get complete, structured progress notes regardless of data entry method.</p> <p>You can use dictation to populate the entire patient chart. You can also load transcribed notes into the patient charts and save the notes as discrete data using the "dot code" feature.</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						
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						Data can be viewed in tables, flow charts, and graphically.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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						<p>You can create up to 100 user-defined fields to store any other patient or guarantor information that you choose.</p> <p>McKesson offers an add-on tool for Practice Partner, Zoom, a full-featured document management system designed to help practices efficiently load outside documents into the EHR. Zoom is fully integrated with Patient Records and allows practices to quickly scan, index, and store paper or faxed documents in the appropriate section of the appropriate patient chart.</p> <p>You can also enter external documentation with the Text Data Loader, by Direct Import of Data, by Dictation, or by Manual Data Entry.</p> <p>Note templates are fully customizable; you can include links to outside information. You can also add Web-links to the system Knowledge Base.</p>

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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						With Zoom, you can quickly scan, index, and store paper or faxed documents in the appropriate section of the appropriate patient chart.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-10	10.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client instructions and client educational materials.	<p>Examples of client instructions and educational materials include: Medication instructions; Tests and procedures instructions; Vaccine instructions; Care access instructions; Etc.)</p> <p>Implies material would be culturally competent and in county threshold languages.</p> <p>See Infrastructure 43.040 and Practice Management 43.006</p>	1						<p>Patient Education provides a comprehensive, computer-based educational module that can be accessed at the point of care via Patient Records. Patient Education consists of an extensive array of handouts on hundreds of medical conditions, procedures, parenting issues, and drug products. With the purchase of a yearly subscription, Patient Education can generate handouts that provide patients with easy-to-read information written in plain, non-medical language. These materials will help physicians better explain conditions and treatment to their patients at the point of care and gives patients up-to-date information that they can take home with them. Patient Education content is provided by McKesson Clinical Reference Systems (Adult Health Advisor, Behavioral Health Advisor, Pediatric Advisor, Senior Health Advisor, and Women's Health Advisor).</p>

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson Corporation

Req. Ctg.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
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						The system captures which Patient Education materials/information was printed/discussed/provided to the patient. And, many of the most common Patient Education modules are available in both English and Spanish versions.
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						Patient Record's progress note templates contain care plans, guidelines, and patient education links.
F-10	10.012	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print a Crisis Management Plan.	Implies that: Plan structure may defined by user; Plan may be prepared by the client and their case manager. Implies integration with other system functions. 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. See Practice Management 43.006	1						You can use the Knowledge Base to store, access and modify emergency procedure and crisis management information.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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						You can incorporate advance directive information in a designated area of the patient chart, and you can record the presence (and type) of Advance Directive as discrete data.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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						An individual patient's lab results information can be viewed and printed from the system. Additionally, using Patient Inquiry you can create reports based on 14 different clinical data parameters including lab results, medications, diagnoses, problems, health maintenance status, and more. For example, you can easily create a report to find all diabetic patients with a hemoglobin A1c value greater than 7.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						<p>Patient Records includes a standard set of flow chart templates you can use to compare and analyze patient information. The flow chart section pulls information from laboratory data, vital signs, medications, and health maintenance. Flow chart templates are fully customizable.</p> <p>Abnormal results are displayed in color (red for higher than normal range, green for lower). If you enter a value that falls in the critical range for a laboratory data item and messaging for critical values was enabled, the patient's providers are automatically alerted by a message sent. The system generates the message automatically. The message contains the critical value for the test performed, the date and time of the test, and the normal and critical ranges for the test.</p>

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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						In addition, you can sign the lab test results and forward them to other providers so that they can review and sign the test results as well
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						<p>Patient Records' progress note templates and health maintenance templates contain care plans, guidelines, and patient education links.</p> <p>You can also use the Knowledge Base to store, access and modify, and print additional care plan, protocol and guideline documents.</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						Note templates are fully customizable. You can create user-defined, required fields to track protocol and care plan compliance. [???] You can add partial note markers to existing notes to indicate points at which text will be inserted later from an uploaded text data file. You can use the REQ label marker to require a user to enter data or text immediately after a marker so that you do not miss entering data in required fields. You cannot save a note permanently if any REQ label marker is missing data. You can use the REQ label marker as many times as necessary in a template.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-19	19.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication administration information.	<p>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.</p> <p>Data shall be stored as discrete data fields.</p> <p>See Practice Management 43.006 and Infrastructure 43.040.</p>	1						You can create a template for medication notes. The Medication list displays information about the patient's current medications. You can use provider dashboard to-do lists to schedule and monitor administration of medication.
F-19	19.003	The system shall provide the ability to document immunization administration.		1						Additionally, you can print immunization reports for school enrollment or travel. Before printing you can determine the health maintenance activities and lab results that will be specified on the report. You can then specify the status or statuses of activities and results included on the report.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						There is a specific portion of the patient chart where allergies and intolerances are documented. The allergy record stores both the allergy name (agent), as well as the type (classified drug allergy, drug intolerance, food allergy, or other), severity (severe, moderate or mild), reaction (e.g., shock, asthma, rash), and code.
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						With the Health Maintenance feature, you can track a patient's preventive and follow up care treatments. You can track a wide variety of items including the entire USPSTF guidelines, cholesterol, immunizations, pap smears, mammograms, chemistry panels, creatinine, HgBA1C, and more. As diagnoses are made and prescriptions are written, the user is prompted to apply protocols for tracking care. Preventive measures are similarly tracked and applied to all patients. Each patient has a summary of overdue items.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-21	21.002	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print alerts based on established guidelines.	Guidelines may be from national organizations, payers, or internal protocols. See Practice Management 43.012	1						Overdue items appear whenever the patient's chart is opened and are highlighted in the patient chart for easy viewing. Patient Records also displays a prompt for overdue items when a patient is scheduled through Appointment Scheduler.
F-21	21.006	The system shall be able to override guideline alerts.	Includes all or part of the alerts.	1						Entering "not applicable" for a procedure will stop all overdue checking for that procedure.
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						You can do this using notes, comments features and user-defined fields.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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						<p>Critical information can be entered as demographic notes or flags, which will display before the chart appears. Allergy information is presented on multiple screens throughout the system, and will trigger an alert upon entry of any medications that pose a risk of reaction.</p> <p>You can also display test/lab results in flow charts using different colors for high, low, critical high, critical low, critical, and abnormal results. In addition, if a value falls in the critical range for a lab data item and critical values messaging was enabled, predesignated providers are automatically alerted.</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						The health maintenance feature helps you track a patient's preventive and follow up care treatments. You can mark an activity/test/procedure as completed, or completed at outside facility.
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						The health maintenance feature helps you track a patient's preventive and follow up care treatments. You can mark an activity/test/procedure as completed, or completed at outside facility.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						<p>The health maintenance feature helps you track a patient's preventive and follow up care treatments. You can mark an activity/test/procedure as completed, or completed at outside facility.</p> <p>You can track a wide variety of items including the USPSTF guidelines, cholesterol, immunizations, pap smears, mammograms, chemistry panels, creatinine, HgBA1C, and more. Health Maintenance can be set up to automatically recognize Vital Sign and Clinical Element data as fulfilling a HM requirement.</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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.	<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 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 notifications and reminders (e.g., contact client 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						<p>The health maintenance feature tracks periodic patient treatments such as examinations, tests, and immunizations. Once you establish health maintenance schedules for specific groups of patients (for example, by sex and age), you can track this information in the patient chart.</p> <p>You can add any number of disease management, preventative and wellness programs to a health maintenance template.</p> <p>The reminder screen shows the health maintenance items that are overdue for the patient. You can set up proactive reminders by scheduling due dates early.</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						Sources include guidelines from the United States Preventive Services Task Force.
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						The Health Maintenance feature provides guidelines and reminder capabilities for disease management preventive and wellness treatments, tests, exams, medications, and procedures.
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						You can set up health maintenance templates for tracking against guidelines and internal protocols and you can customize, disable, or override those templates as needed.
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						All overdue Health Maintenance items appear in a pop-up window as soon as the patient's chart is opened.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						The system suggests appropriate Health Maintenance templates that can be applied to each patient based on specifics such as gender, age, and diagnosis.
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						You can Print a complete patient chart, a chart summary, or use the Partial Chart Report command to print only selected parts of a patient chart for the range of dates you specify. Ability to print certain information can be defined at the user role/access level.
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						You can print a Chart Summary, a Partial Chart Report or a Complete Chart Report.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-29	29.003	The system shall be able to generate Health Record hardcopy and electronic output by date and/or date range.		1						You can use the Partial Chart Report command to print only selected parts of a patient chart for the range of dates you specify.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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						Practice Partner software provides powerful privacy and security features to facilitate compliance with the Privacy and Security provisions of HIPAA. While software technically cannot be "HIPAA compliant," a system can support HIPAA-compliant data security and practices, as Practice Partner does fully. You can use the data export feature to determine which fields you export. You can choose to export numeric data only, you can choose to exclude the patient's name and you can choose to replace the Patient ID with a pseudo-identifier.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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						We are directly involved in many industry standards development efforts, and continue to develop our software to meet emerging standards that help our customers improve patient care and efficiency or maintain statutory and regulatory compliance.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-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						Patient Records has flexible data entry methods to suit different physician styles including: keyboard, speech recognition (integrated with Dragon NaturallySpeaking for both data entry and commands), touch screen, handwriting recognition, and dictation. You get complete, structured progress notes regardless of data entry method. You can print, modify, update, copy the information and so forth.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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-30	30.003	The system shall be able to associate individual service / treatments with diagnoses.		1						As diagnoses are made and prescriptions are written, the user is prompted to apply relevant protocols for tracking care. Preventive measures are similarly tracked and applied to all patients.
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						Using Patient Inquiry, reports can be generated (and displayed on screen), filtered by provider, diagnosis, and virtually any other discrete data element in the system, including user-defined fields.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Clinical Data - McKesson 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-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						The drug database is updated monthly. ICD-9/CPT code databases are updated annually. Other clinical content such as progress note and health maintenance templates are updated on an as-needed basis, incorporated in software updates and upgrades.
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						Refer to item 34.002
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						You can use Immunization–Status Selection to print a report of selected health maintenance activities and lab results. This report may be used for school enrollment, travel, or sending to an immunization registry.

CA Department of Mental Health
BH-EHR Requirements Survey

Clinical Data - McKesson 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						The system administrator can use Immunizations Selection to set up the Immunization Report and determine which Health Maintenance and Laboratory items will be on the report.
Clinical Data Totals:			<i>Number of Requirements</i>	95	0	0	0	0	3	
				<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
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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						Via the ePrescribing feature, information about prescriptions that have been filled for the patient at retail and mail-order pharmacies can be downloaded and displayed in the patient's chart, printed, and so forth.
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						The ePrescribing module connects your practice with the SureScripts® Electronic Prescribing Network and the RxHub National Patient Health Information Network™. Together these services provide a comprehensive ePrescribing solution for providers and their staff, with connectivity to thousands of pharmacies and PBMs nationwide.
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						The Universal Time Code (UTC) timestamp is recorded in the audit record for all user activity, including prescription ordering and signature.

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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						Rx/Medications may be configured to require the use of an electronic signature (PIN) when writing DEA restricted and/or non-restricted prescriptions. The PIN serves as a signature or co-signature on the prescription. If an Rx requires a co-signature, it is placed in suspended status until the co-signature is obtained. Prescription signing, printing, faxing, and transmitting are recorded for audit trail purposes.
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						NDC codes can be associated with prescriptions in the system.
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						Patient Records conducts several checks when a clinician writes a prescription, including drug-dose checking using the Dose Advisor tool.
F-11	11.010	The system shall be able to check for dose ranges based on client age and weight.		1						Patient Records conducts several checks when a clinician writes a prescription, including drug-dose checking.

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-11	11.011	The system shall be able to select a drug by therapeutic class.	As available through 3rd-party drug databases.	1						Practice Partner provides access to a (subscription) drug database provided by Medi-Span, part of Wolters Kluwer Health. You can select a medication belonging to a class of medication at the time you display the laboratory data table or flow chart.
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						When the patient's chart is opened Practice Partner instantly checks the RxHub network for the patient's eligibility. If there is existing data in eligibility tab, it will be replaced with the most recent pharmacy benefits eligibility data.
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						Patient Records automatically queries the formulary associated with the primary insurance carrier listed in the patient's demographic section. We provide the formulary database through a partnership with MediMedia. When ordering, the system will alert the user of a duplicate order.
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-11	11.015	The system shall be able to print and electronically fax prescriptions.	Appropriate audits and security shall be in place.	1						<p>You can integrate a Windows 2003 fax server or Zetafax with Practice Partner to enable fax server faxing for Rx prescriptions, notes and reports in Patient Records.</p> <p>The system's audit trail functionality includes recording of prescription printing, faxing, and transmitting.</p>
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						<p>Users can initiate a re-print or re-fax. The system will alert the user if items failed to print/fax correctly so an error can be corrected.</p> <p>The system's audit trail functionality includes recording of prescription printing, faxing, and transmitting.</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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 ePrescribing module connects your practice with the SureScripts® Electronic Prescribing Network and the RxHub National Patient Health Information Network™. Together these services provide a comprehensive ePrescribing solution for providers and their staff, with connectivity to thousands of pharmacies and PBMs nationwide.
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						The Dose Advisor feature uses the patient's demographic (e.g., weight, age), clinical information and prescribed medication data to calculate a recommended dosage for the patient. A button for this feature is provided on the prescription entry page.
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						The Dose Advisor feature uses the patient's demographic (e.g., weight, age), clinical information and prescribed medication data to calculate a recommended dosage for the patient.
F-11	11.020	The system shall be able to display client specific dosing recommendations based on renal function.	On roadmap for 2010	1						Dose Advisor incorporates creatinine results.

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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						
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						You can use a dosage amount recommended by the Dose Advisor, or you can choose to enter a different dose (including fractions). You can change any of the values if you disagree with the recommended dose. You can also change values entered on this screen and re-calculate the dose. Once you are satisfied with the dose, click the OK button. The Size, Take, Frequency, and Duration fields on the Prescription screen will be filled in with the corresponding values from the Dose Advisor screen.

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-11	11.024	The system shall be able to prescribe non-NDC coded medications.		1						The medication master list in Practice Partner is not NDC-based because NDC specifies drugs at a level of specificity finer than what is of concern to the prescribing physician in most instances (i.e., NDC is specific to manufacturer, packaging, etc.).
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						You can look up or type in up to two indications when writing a prescription. You can add multiple indications to a medication template in a formulary.
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-11	11.031	The system shall provide links to general prescribing information at the point of prescribing.	Example: Physician Desk Reference (PDR)	1						The Practice Partner Knowledgebase includes resources such as a drug database, and clinical guidelines and care plans from the Agency for Health Care Policy and Research and the US Preventive Services Task Force. Many clients store other decision support files in the Knowledge Base or link to information available on the Web. Using Patient Record's progress note templates, you can build links that access knowledge base documents or Web pages. This provides decision support at the point of care, when it's needed.
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						You can use the provider dashboard to track follow up tests followup tests based on medication prescribed.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Computerized Provider Order Entry(CPOE) - McKesson 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-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						<p>You can use Order Entry to electronically enter, review, delete, print and report on laboratory, radiology, pathology, and other diagnostic tests. You can mark procedures as completed, refused, done elsewhere, not applicable to the patient, offered but postponed, or ordered.</p> <p>You can pre-load virtually every order possible into the system. Orders that have not been started display on the review screen's Pending tab.</p>
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						You can select up to four diagnosis codes for each order.

**CA Department of Mental Health
BH-EHR Requirements Survey**

Computerized Provider Order Entry(CPOE) - McKesson 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-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						You can require one or more signatures for each order (a PIN established by either the system administrator or provider). Order Entry's audit trail automatically tracks the date, time, and signature of orders.
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						You can set up Processing Dialogs to capture data when an operator is processing orders in Practice Partner.
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						You can set up both in-house and external facilities to process and fulfill orders. Orders can be faxed, printed, or sent electronically via the ePrescribe system (SureScripts/RxHub).

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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						<p>Order Entry provides several built-in reports that you can use to monitor ordering benchmarks. For example, you can print statistical reports that include:</p> <ul style="list-style-type: none"> • Number, type, and status of orders for specific provider (who's ordering what tests) • Number, type, and status of orders for specific patients • Turnaround times for processing orders (how long tests take to be completed) • Tests that are overdue <p>You can also print financial reports that indicate spending and cost patterns. Using the Patient Inquiry query tool, you can run a report for all orders issued by type (e.g., radiology).</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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						<p>You can set up user defined rules on the order's appropriateness (based on diagnosis, laboratory values, medications, allergies, etc.).</p> <p>You can use rule files to determine when and how a procedure should be accomplished. Practice Partner has several built-in rule options (for example, "do once " or "do at ages . . ."), but practices can use rule files to expand on the rule logic.</p> <p>The system also provides coding support for appropriate coding based on medical criteria.</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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						<p>You can select individual orders you want to group. You can use the Grouped Orders screen to automatically view and/or send grouped orders (based on the same patient, facility and processing dialog).</p> <p>Practices can configure Order Sets that initiate several orders as a group at once. You can use a single order to initiate frequently used orders. You can enter an order set that is made up of a series of orders, instead of initiating each order separately for the patient.</p> <p>You can use the Autoissue to process future orders and order sets automatically when their dates come due.</p>
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						You can do this with visible order sets, where the individual (component) orders appear on the Order screen when the order set is selected and effectively become individual orders.

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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						Order status appears automatically in the provider's dashboard results inbox once the completed order or denial is received by the system.
F-14	14.011	The system shall allow user acknowledgment of a result presentation.	This is separate from audit trail.	1						After a user has reviewed a test result set, a user can click the Sign button to enter electronic signature to acknowledge review of the result, if required.

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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.	<p>Implies meeting standards for client confidentiality (e.g., HIPAA) and electronic transfer protocols (e.g., HL7 based).</p> <p>In addition to lab and radiology reports, this might include interfaces with case/disease management programs and others.</p> <p>See Clinical 14.001and 14.003</p>	1						The Practice Partner applications can interface (via HL7 and other standard protocols such as (via HL7 and other standard protocols such as as ASTM/CCR, NCPDP Script, X12 (HIPAA), and XML) with external sources. We have developed interfaces to all of the major clinical reference labs, such as Quest Diagnostics and LabCorp; the major practice management systems, such as Medical Manager and IDX; hospital systems, such as Cerner and MediTech; radiology systems; lab information systems; interface engines; and many other specialized systems. Depending on the specifications of any particular interface, there may be a fee for set up and maintenance of interfaces.

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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						<p>The Practice Partner applications can interface with external sources such as commercial labs, and on site lab equipment. The Practice Partner system currently interfaces with the following medical devices:</p> <ul style="list-style-type: none"> <input type="checkbox"/> IQmark Digital ECG and Spirometer by Midmark Diagnostics Group <input type="checkbox"/> Welch Allyn Vital Signs Monitor <input type="checkbox"/> Welch Allyn CardioPerfect Resting ECG module <input type="checkbox"/> Lifescan One-Touch, Roche Accu-Chek, Bayer Ascensia, and TheraSense FreeStyle glucose meters <p>Depending on the specifications of any particular interface, there may be a fee for set up and maintenance of interfaces.</p>

**CA Department of Mental Health
BH-EHR Requirements Survey**

Computerized Provider Order Entry(CPOE) - McKesson 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-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</p>	1						<p>The system automatically performs the checks when the prescription is written. If the system detects a potential problem, it will present information on the onset, severity, and documentation of the issue, including a summary of pertinent studies from medical literature.</p> <p>You can select your screening criteria based on the severity and level of documentation of the drug interaction. The result: clinicians are presented with drug interaction warnings only when they meet or exceed the user selected minimum threshold for interaction screening</p>

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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						The user can override warnings for interactions and/or allergies being present.
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						If the Drug Interaction database is installed, you can specify the minimum severity of interaction to display.
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						When a medication is prescribed, the system automatically applies the relevant prescription template to that patient. Prescription templates include necessary tests to monitor for therapeutic or adverse effects of the medication.
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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						Patient Records includes a comprehensive drug database, provided through a partnership with MediSpan, a division of Wolters Kluwer Health. The system automatically performs the checks when the prescription is written. If the system detects a potential problem, it will present information on the onset, severity, and documentation of the issue, including a summary of pertinent studies from medical literature.
F-18	18.016	The system shall support accessibility of drug specific education materials from third party databases.		1						Patient Education provides a comprehensive, computer-based educational module that can be accessed at the point of care via Patient Records. Patient Education consists of an extensive array of handouts on hundreds of medical conditions, procedures, parenting issues, and drug products. You can also use the built-in browser to access your own custom local knowledge base, and to surf the Web if you have Web access.

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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						Medi-Span provides a comprehensive drug database updated monthly.
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						

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-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.	<p>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.</p> <p>Until electronic standards are established, FAX is a suitable means of transmission.</p>	1						Practice Partner Order Entry can fax (via integrated fax server capability), print or electronically transmit prescriptions. With the ePrescribing module, you can transmit prescriptions and refill requests and access prescription benefit eligibility, formulary and coverage, and medication fill history information at the point of care, all electronically. The ePrescribing module connects your practice with the SureScripts® Electronic Prescribing Network and the RxHub National Patient Health Information Network™. Together these services provide a comprehensive ePrescribing solution for providers and their staff, with connectivity to thousands of pharmacies and PBMs nationwide.
I-02	2.004	The system shall be able to order radiology tests.		1						In addition, electronic interfaces can be set up to a variety of remote and internal laboratory, radiology, and other systems.

CA Department of Mental Health
BH-EHR Requirements Survey

Computerized Provider Order Entry(CPOE) - McKesson 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-02	2.005	The system shall be able to order and schedule radiology tests.		1						
CPOE Totals:				54	0	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>	

**CA Department of Mental Health
BH-EHR Requirements Survey**

Electronic Health Record (EHR) - McKesson 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						
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						Depending on the format and nature of information and the interchange method, there may be a charge for the creation of interfaces to the Practice Partner system, or for data conversion services.
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						Via Order Entry/Lab Data Loader
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						Via Order Entry/Lab Data Loader

CA Department of Mental Health
BH-EHR Requirements Survey

Electronic Health Record (EHR) - McKesson 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-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						Providers who are also Practice Partner system users can be given access to laboratory results of a patient in the system. External providers can be given access to patient chart information via the Web View portal. (Not an automated system query/response - user initiated activity)
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						Via Order Entry
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	No query capability. Overdue Orders report allows detection of orders with no results.
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						Via Order Entry

CA Department of Mental Health
BH-EHR Requirements Survey

Electronic Health Record (EHR) - McKesson 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-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						Using the internal messaging system (for other providers using the same Practice Partner system). Using external messaging capabilities for outside Providers. Electronic files received from an external provider can be loaded into the Patient's chart using the Zoom document tool. (Not an automated system query/response - user initiated activity)
I-02	2.003	The system shall be able to respond to a query to share imaging results with other providers		1						Providers who are also Practice Partner system users can be given access to laboratory results of a patient in the system. External providers can be given access to patient chart information via the Web View portal. (Not an automated system query/response - user initiated activity)

CA Department of Mental Health
BH-EHR Requirements Survey

Electronic Health Record (EHR) - McKesson 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	3.002	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						The system can support processing refill requests via the ePrescribing feature - refer to the attached Product Bulletin
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						Via the ePrescribing feature - refer to the attached Product Bulletin
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						Via the ePrescribing feature - refer to the attached Product Bulletin
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						Via the ePrescribing feature - refer to the attached Product Bulletin
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						Via the ePrescribing feature - refer to the attached Product Bulletin
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						Via the ePrescribing feature - refer to the attached Product Bulletin
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	

**CA Department of Mental Health
BH-EHR Requirements Survey**

Electronic Health Record (EHR) - McKesson 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-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	
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	
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	
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						Using letter templates and via Order Entry. Additionally, external providers can be granted secure access to portions of a patient's chart via the Web View portal.

CA Department of Mental Health
BH-EHR Requirements Survey

Electronic Health Record (EHR) - McKesson 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-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						Practice Partner fully supports the CCR for both input and output. On input, in addition to the entire document, structured data such as demographics, problems, medications, vitals, and labs can flow into the chart. On output, a complete CCR record is created. Practice Partner also provides CCD capability.
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						Depending on the mode or transmittal and data format, e.g., HL7. May incur additional costs for the set up of an appropriate interface or for data conversion services.

CA Department of Mental Health
BH-EHR Requirements Survey

Electronic Health Record (EHR) - McKesson 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-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						Practice Partner fully supports the CCR for both input and output. On input, in addition to the entire document, structured data such as demographics, problems, medications, vitals, and labs can flow into the chart. On output, a complete CCR record is created. Practice Partner also provides CCD capability.
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						Practice Partner fully supports the CCR for both input and output. On input, in addition to the entire document, structured data such as demographics, problems, medications, vitals, and labs can flow into the chart. On output, a complete CCR record is created. Practice Partner also provides CCD capability.

CA Department of Mental Health
BH-EHR Requirements Survey

Electronic Health Record (EHR) - McKesson 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-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						<p>The Practice Partner system currently interfaces with the following home medical devices:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lifescan One-Touch, Roche Accu-Chek, Bayer Ascensia, and TheraSense FreeStyle glucose meters (directly imports blood glucose meter readings and related information into Patient Records) <p>The Practice Partner system also interfaces with the following office medical devices:</p> <ul style="list-style-type: none"> <input type="checkbox"/> IQmark Digital ECG and Spirometer by Midmark Diagnostics Group (electronically stores all ECGs and their interpretations and spirometry information in patient charts without scanning) <input type="checkbox"/> Welch Allyn Vital Signs Monitor (electronically acquires, displays, and stores vital sign results) <input type="checkbox"/> Welch Allyn

**CA Department of Mental Health
BH-EHR Requirements Survey**

Electronic Health Record (EHR) - McKesson 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-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						A report containing user-selected data can be generated using Patient Inquiry, for sending to designated agencies.
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						A report containing user-specified utilization and laboratory data (anonymous) can be generated using Patient Inquiry, for sending to designated agencies.
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					

**CA Department of Mental Health
BH-EHR Requirements Survey**

Electronic Health Record (EHR) - McKesson Corporation

Req. Ctg.	Req. Nbr.	Requirement Description	DMH Comment	Existing	Planned	Modification	Custom	3rd Party	Not Addressed	Vendor Comment
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	Additional clarification/definition needed
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	Additional clarification/definition needed
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						Depending on the format and nature of information and the interchange method, there may be a charge for the creation of interfaces to the Practice Partner system.

CA Department of Mental Health
BH-EHR Requirements Survey

Electronic Health Record (EHR) - McKesson 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-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				Authorizations cannot be received electronically, but if authorization data is entered in the system, the system will track the number of authorized visits and provide an alert if visits are due to run out.
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						A report containing information to respond to such a query can be generated by a user with the Patient Inquiry ad hoc reporting tool.
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	
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>	25	1	1	0	0	10	
				<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
BH-EHR Requirements Survey**

Personal Health Record (PHR) - McKesson 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	6.014	The system shall be able to input, modify, inactivate, delete, update, display, and print information from a personal health record (PHR).		1						Practice Partner is not designed as a comprehensive PHR system. However, a complete or partial patient chart can be input, modified, inactivated, deleted, updated, displayed and printed from the system
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	Practice Partner is not designed as a comprehensive PHR system. However, a complete or partial patient chart can be input, modified, inactivated, deleted, updated, displayed and printed from the system
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 data can be provided to an outside entity from the patient's chart, but the system is not designed to generate an automated response to a PHR system.

CA Department of Mental Health
BH-EHR Requirements Survey

Personal Health Record (PHR) - McKesson 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	4.003	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 data can be imported into a patient's Practice Partner chart via the import methods
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						Practice Partner is not designed as a comprehensive PHR system. However, a patient ("client") can review information from their Practice Partner chart via the Web View portal or a chart can be printed or exported for review directly.
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						A patient ("client") can review information from their Practice Partner chart via the secure Web View portal.
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						A patient ("client") can input registration information and medical/family/social history via the Web View portal and this information will automatically populate the client's Practice Partner chart.

CA Department of Mental Health
BH-EHR Requirements Survey

Personal Health Record (PHR) - McKesson 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>
PHR Totals:			<i>Number of Requirements</i>	5	0	0	0	0	2	
			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
BH-EHR Requirements Survey
Response Summary**

Company Name:	McKesson Corporation								
Product Name:	Practice Partner Patient Records, Practice Partner Order Entry, Practice Partner Appointment Scheduler, Practice I								
DMH Roadmap Category	Nbr of Reqs.	Met by Existing Functionality	Within 12 Months	Requires Software Modifications	Requires Custom Development	Requires Third Party	Not Addressed	No Response	Invalid Response
Infrastructure	96	70	2	0	1	0	23	0	0
		73%	2%	0%	1%	0%	24%	0%	0%
Practice Mgmt	162	127	1	2	3	6	23	0	0
		78%	1%	1%	2%	4%	14%	0%	0%
Clinical Data	98	95	0	0	0	0	3	0	0
		97%	0%	0%	0%	0%	3%	0%	0%
CPOE	54	54	0	0	0	0	0	0	0
		100%	0%	0%	0%	0%	0%	0%	0%
EHR	37	25	1	1	0	0	10	0	0
		68%	3%	3%	0%	0%	27%	0%	0%
PHR	7	5	0	0	0	0	2	0	0
		71%	0%	0%	0%	0%	29%	0%	0%
Total	454	376	4	3	4	6	61	0	0
		83%	1%	1%	1%	1%	13%	0%	0%