

# California Department of Mental Health Electronic Health Record Functionality Survey

The functional requirements in this survey are organized into the following categories of the DMH Integrated Information System Roadmap:

1. Infrastructure
2. Practice Management
3. Clinical Data Management
4. Computerized Provider Order Entry (CPOE)
5. Fully Interoperable Electronic Health Record (Full EHR)
6. Personal Health Record

For each requirement in this survey please indicate which of the following responses best describes your current solution. Indicate your selection by keying a numeric '1' into the appropriate cell. To remove a previously entered value, use the Delete key. Do NOT use the space bar to blank out a previously entered value because spaces are not allowed in the cell.

Response Code	Response Title	Response Description
EX	Existing	The vendor's solution meets the functional requirement 'out of the box' as an existing component of its base product without any effort over and above code table configuration. This response indicates that no programming customization is required to meet the requirement.
PL	Planned	The vendor's solution does not presently meet the functional requirement 'out of the box', but an upgrade to the base product that will meet this requirement is planned within the next 12 months. This response indicates that no programming customization will be required to meet the requirement.
MOD	Modification	The vendor's solution does not meet the functional requirement 'out of the box', but will meet the functional requirement with a programming modification to the base product. <b>NOTE: Please put the estimated number of programming hours in the Comments.</b>
CD	Custom Development	The vendor's solution does not meet the functional requirement 'out of the box' nor with any level of modification to the existing code base. The vendor will meet this functional requirement by developing custom software. <b>NOTE: Please put the estimated number of programming hours in the Comments.</b>
TP	Third Party	The vendor's solution does not meet the functional requirement 'out of the box' nor with any level of customization, but will meet the functional requirement by integrating third party solution(s). <b>NOTE: Please identify the 3rd party vendor and product in the Comments.</b>
CM	Cannot Meet	The vendor cannot meet this functional requirement. Please indicate the reason why the requirement cannot be met in the Comments.

**California Department of Mental Health  
Electronic Health Record Functionality Survey**

<b>Company Name</b>				
<b>Company Address</b>				
<b>Company Web Site</b>				
<b>Product Name(s)</b>				
<b>Primary Contact Name</b>				
<b>Primary Contact Phone</b>				
<b>Primary Contact eMail</b>				

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Infrastructure									
F35	Enforcement of Confidentiality		Vendor's Response						
Number	Description	DMH Comment	EX	PL	MOD	CD	TP	CM	Vendor Comment
35.001	The system shall be able to audit the date/time and user of each instance when a client chart is printed by the system.	Does not include screen print and other functions that are external to the programmed functionality of the EHR system.							
35.002	The system shall provide a means to document a client's dispute with information currently in their chart.	This does not imply that the client can document directly in their chart. Some methods include but are not limited to allowing the client a view only access to their record or printing a copy of the record for a client to review. Methods to include the information in the chart could be as a note, a scanned copy of client comments, an addendum to the note or other method not described.							
35.003	The system shall be able to identify all users who have accessed an individual's chart over a given time period, including date and time of access.	Specific items/sections of information accessed shall be identified, with appropriate audit trail.							
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 chart							
35.005	The system shall be able to prevent specified user(s) from accessing a designated client's chart	An example would be preventing access to a VIP or staff member's chart. 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.							

<b>Infrastructure</b>									
<b>F36</b>	<b>Data Retention, Availability and Destruction</b>		<b>Vendor's Response</b>						
<b>Number</b>	<b>Description</b>	<b>DMH Comment</b>	<b>EX</b>	<b>PL</b>	<b>MOD</b>	<b>CD</b>	<b>TP</b>	<b>CM</b>	<b>Vendor Comment</b>
36.001	The system shall be able to retain data until otherwise purged, deleted, archived or otherwise deliberately removed.								
36.002	The system shall provide a method for archiving health record information.	Archiving is used to mean information stored in a retrievable fashion without defining where or how it is stored.							
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.							
36.004	The system shall be able to store and retrieve health record data and clinical documents for the legally prescribed timeframes.								
36.005	The system shall be able to retain inbound data or documents (related to health records), as originally received (unaltered, inclusive of the method in which they were received), for the legally prescribed time frames, in accordance with users' scope of practice, organizational policy or jurisdictional law.								
36.006	The system shall be able to retrieve information in a manner conducive to recreating the context in which the information was obtained.								
36.007	The system shall be able to retrieve all the elements included in the definition of a legal health (medical) record.								
36.008	The system shall provide for oversight, review and confirmation of record(s) destruction prior to destroying specific EHR data/records.								
36.009	The system shall be able to destroy EHR data/records so that all traces are unrecoverable, according to policy and legal retention periods.								
<b>Infrastructure Totals:</b>		<b>Number of Requirements</b>	<b>EX</b>	<b>PL</b>	<b>MOD</b>	<b>CD</b>	<b>TP</b>	<b>CM</b>	
		14	0	0	0	0	0	0	

<b>Practice Management</b>											
<b>F01</b>	<b>Identify and Maintain a Client Record</b>				<b>Vendor's Response</b>						
<b>Number</b>	<b>Description</b>	<b>DMH Comment</b>	<b>EX</b>	<b>PL</b>	<b>MOD</b>	<b>CD</b>	<b>TP</b>	<b>CM</b>	<b>Vendor Comment</b>	<b>Missing/Invalid</b>	
1.001	The system shall allow creation of an EHR that is uniquely associated to a single client.									1	
1.002	The system shall associate (store and link) key identifier information (e.g., system ID, health record number) with each client record.	Key identifier information shall be unique to the client record but may take any system defined internal or external form.								1	
1.003	The system shall provide functionality to record multiple non medical record identifier for single client. (e.g. SNN, pseudo SNN, and CIN, Drivers License or St ID#)	For interoperability, practices need to be able to store additional client identifiers. Examples include an ID generated by an Enterprise Master Patient Index, a health plan or insurance subscriber ID, regional and/or national client identifiers if/when such become available.								1	
1.004	The system shall provide a field to identify the identifier type.									1	
1.005	The system shall use key identifying information to identify (look up) the unique client record.									1	
1.006	The system shall provide more than one means of identifying (looking up) a client.	Examples of identifiers for looking up a client include date of birth, phone number.								1	
1.007	The system shall provide a field or fields which will identify clients as being exempt from reporting functions. Note: Work with DMH to review this item for Behavioral Health.	Examples include clients who are deceased, transferred, moved, seen as consults only. Being exempt from reporting is not the same as de-identifying a client who will be included in reports. De-identifying clients for reporting is addressed in the "Health record output" functionality.								1	
1.008	The system shall allow the user to choose from which reporting functions client identifiers shall be excluded.	Example: Exclude from case load reports but include in CSI reporting.								1	
1.009	The system shall be able to merge duplicate client records including claim data, demographic, financial, clinical and all service/treatment data.	If a duplicate chart is created, information could be merged into one chart.								1	

<b>1.010</b>	The system shall provide a mechanism for user to designate which merging data elements are to be retained as the primary record. Retain all records and mark the file as merged. Account for and store deleted MRN with cross reference.										1
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<b>Practice Management</b>											
<b>F02</b>	<b>Manage Client Demographics</b>		<b>Vendor's Response</b>								
<b>Number</b>	<b>Description</b>	<b>DMH Comment</b>	<b>EX</b>	<b>PL</b>	<b>MOD</b>	<b>CD</b>	<b>TP</b>	<b>CM</b>	<b>Vendor Comment</b>	<b>Missing/Invalid</b>	
2.001	The system shall capture and maintain demographic information as part of the client record. This information shall be able to be included in reports. Demographic data shall be able to accommodate minimum data sets as established by various regulatory bodies and reporting requirements..	Examples of a minimum set of demographic data elements include: name, address, phone number and date of birth. It is assumed that all demographic fields necessary to meet legislative and regulatory (e.g., HIPAA), research, and public health requirements will be included. A desirable feature would be a method of identifying how clients would like to be contacted (e.g., alternate addresses). De-identifying demographic information is addressed in the "Health record output" functionality.								1	
2.002	The system shall be able to maintain and make available historic information record using effective and end dates for demographic data including prior names, addresses, phone numbers and email addresses.									1	
2.003	The system shall be able to maintain client contact/relationship information such as emergency contact and parents or guardians of children with effective dates. Includes ability to designate type of relationship and contact information.									1	
2.004	The system shall be able to import, create, review, modify, delete, and inactivate demographic information about the client.									1	
2.005	The system shall store demographic information in the client health record in separate discrete data fields, such that data extraction tools can retrieve these data.									1	
2.006	The system shall allow user to define additional fields to collect client demographic data required for California state-wide reporting.									1	
<b>Practice Management Totals:</b>		<b>Number of Requirements</b>	<b>EX</b>	<b>PL</b>	<b>MOD</b>	<b>CD</b>	<b>TP</b>	<b>CM</b>		<b>Missing/Invalid</b>	
		16	0	0	0	0	0	0		16	

<b>Clinical Data Management</b>										
<b>F03</b>	<b>Manage Diagnosis List</b>	<b>Vendor's Response</b>								
<b>Number</b>	<b>Description</b>	<b>DMH Comment</b>	<b>EX</b>	<b>PL</b>	<b>MOD</b>	<b>CD</b>	<b>TP</b>	<b>CM</b>	<b>Vendor Comment</b>	
3.001	The system shall be able to display current multi-axial diagnoses associated with a client.	We assume current and active to mean the same thing.								1
3.002	The system shall be able to maintain a history of all diagnoses 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
3.003	The system shall be able to maintain the onset date of the diagnoses.	It is a vendor design decision whether to require complete date or free text of approximate date.								1
3.004	The system shall be able to record the chronicity (chronic, acute/self-limiting, etc.) of a diagnoses.									1
3.005	The system shall be able to record the user ID and date of all updates to the diagnoses.									1
3.006	The system shall be able to associate orders, medications, and notes with one or more diagnoses.	One shall be able to identify all visits for a particular diagnosis/problem. . Association can be made in structured data or in non-structured data.								1
3.007	The system shall be able to associate orders, medications and notes with one or more diagnoses; association to be structured, codified data.									1
3.008	The system shall be able to maintain a coded list of diagnoses.	For example: ICD-9 CM, ICD-10 CM, SNOMED-CT, DSM-IV. The Functionality WG will not specify which code set(s) are to be employed.								1
3.009	The system shall be able to validate that the coded diagnosis is valid for the axis in which its entered.									1
3.010	The system shall provide links to the diagnosis validation tables and shall be able to locally manage the table.	Provide categorization by Axis. To assist clinician in accurate documentation display diagnosis code and name upon diagnosis code entry to EHR system.								1
3.011	The system shall be able to display inactive and/or resolved diagnoses.									1

<b>Clinical Data Management</b>										
<b>F04</b>	<b>Manage Medication List</b>	<b>Vendor's Response</b>								
<b>Number</b>	<b>Description</b>	<b>DMH Comment</b>	<b>EX</b>	<b>PL</b>	<b>MOD</b>	<b>CD</b>	<b>TP</b>	<b>CM</b>	<b>Vendor Commenting/Inv</b>	<b>Weighting/Inv</b>
4.001	The system shall be able to create and maintain medication lists.	The medication list shall be "client-centric" and shall include medications prescribed by any provider.								1
4.002	The system shall be able to expressly indicate that the medication list has been reviewed by both the provider and client; this shall be a structured field.									1
4.003	The system shall be able to record prescribed medications information including the identity of the prescriber.									1
4.004	The system shall be able to maintain medication ordering dates									1
4.005	The system shall be able to record lab results, future lab types and lab work required for medication monitoring .									1
4.006	The system shall be able to maintain other dates associated with medications including start, modify, renewal and end dates as applicable.									1
4.007	The system shall be able to display medication history for the client. Minimum requirements are: Type, frequency, effective start date and end date, and dosage.	For clarification, medication history includes all medications prescribed since the EMR was established.								1
4.008	The system shall be able to capture medications entered by authorized users other than the prescriber.	It is important to have all current medications in the system for drug interaction checking. This in the future would include the incorporation of medication history obtained from external electronic interfaces, e.g., from insurers, PBMs, etc. "User" means medical and non-medical staff who are authorized by policy to enter prescriptions or other documentation.								1
4.010	The system shall be able to store the following information about medications: start/stop dates, prescriber, date/time last taken, side effects.									1

<i>Clinical Data Management Totals:</i>		<i>Number of Requirements</i>	<i>EX</i>	<i>PL</i>	<i>MOD</i>	<i>CD</i>	<i>TP</i>	<i>CM</i>	<i>Missing/Inv</i>	
		20	0	0	0	0	0	0		20

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<b>Computerized Provider Order Entry (CPOE)\</b>										
<b>F04</b>	<b>Manage Medication List</b>	<b>Vendor's Response</b>								
<b>Number</b>	<b>Description</b>	<b>DMH Comment</b>	<b>EX</b>	<b>PL</b>	<b>MOD</b>	<b>CD</b>	<b>TP</b>	<b>CM</b>	<b>Vendor Comment</b>	<b>Missing/Invalid</b>
4.009	The system shall be able to capture, store and display medication history received electronically.									1
4.010	CPOE eRX: The system shall provide the ability to create customized preference lists based on the clinical findings of the patient									1
4.011	CPOE eRX: The system shall be able to display the medication history of client ordered by service provider AND other medical providers outside the clinic.									1
<b>Computerized Provider Order Entry (CPOE)\</b>										
<b>F11</b>	<b>Order Medication</b>	<b>Vendor's Response</b>								
<b>Number</b>	<b>Description</b>	<b>DMH Comment</b>	<b>EX</b>	<b>PL</b>	<b>MOD</b>	<b>CD</b>	<b>TP</b>	<b>CM</b>	<b>Vendor Comment</b>	<b>Missing/Invalid</b>
11.001	The system shall be able to create prescription or other medication orders with sufficient information for correct filling and administration by a pharmacy.	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.								1
11.002	The system shall be able to record user and date stamp for prescription related events, such as initial creation, renewal, refills, discontinuation, and cancellation of a prescription.									1
11.003	The system shall be able to capture the identity of the prescribing provider for all medication orders									1
11.004	The system shall allow authorized individuals to cosign medication orders.									1
11.005	The system shall be able to update newly prescribed prescriptions medications.									1

11.006	The system shall have search capacity to provide a list of medications by both generic and brand name.												1
<b>Computerized Provider Order Entry (CPOE) Totals:</b>		<b>Number of Requirements</b>	<b>EX</b>	<b>PL</b>	<b>MOD</b>	<b>CD</b>	<b>TP</b>	<b>CM</b>					<b>Missing/ Invalid</b>
		9	0	0	0	0	0	0					9

Fully Interoperable Electronic Health Record (EHR)										
F24	Inter-Provider Communication	Vendor's Response								
Number	Description	DMH Comment	EX	PL	MOD	CD	TP	CM	Vendor Comment	Missing/Invalid
24.004	The system shall efficiently integrate with community resource databases, client wait lists, call logging, intake screening, pre-registration, registration, remote registration, and client referral systems which gather and/or distribute client demographic and financial information related to an existing or potential client.									1
24.005	The system shall support service/treatment authorization opening, approval, deferral, denial, notice issuance, letter generation, tracking and closing for a variety of authorization types (e.g. acute inpatient, residential, outpatient), which constitute discrete episodes of care, compliant with the ASC X12N 278 - Referral Certification and Authorization format.	Includes: 1) County-Issued Internal Authorizations for clients served at county clinics; 2) County-Issued External Authorizations for clients referred to providers in the provider network as part of the county's role as a Medi-Cal mental health plan; 3) Health Plan-Issued External Authorizations to the county from other health plans and managed care companies, which are approving service/treatments to be provided by county staff or contractors.								1
24.015	The system shall receive and upload, with proper edit checking, client registration, episode, admission, discharge, authorization, and service/treatment data from contract providers that utilize a different practice management system.									1

Fully Interoperable Electronic Health Record (EHR)										
101	Interoperability: Laboratory	Vendor's Response								
Number	Description	DMH Comment	EX	PL	MOD	CD	TP	CM	Vendor Comment	Missing/Invalid
1.001	The system shall receive general laboratory results (includes ability to replace preliminary results with final results and the ability to process a corrected result)	The test files are designed so that products implementing either the HL7 v2.4 or HL7 v2.5.1 standard will be found compliant. The test identifier will be encoded in LOINC, and will be drawn from among 52 common test codes. Refer to 2007 CCHIT Laboratory Interoperability Test Instructions and Applicant Form for the list of these codes and more information on the interoperability test procedure.								1
1.002	The system shall receive microbiology laboratory results	Organisms will be coded using SNOMED, Sensitivity testing will be coded using LOINC								1
1.003	The system shall respond to a query to share laboratory results	Part of ONC EHR-Lab Use Case  Will work with Ambulatory Functionality WG to align functionality criteria and interoperability roadmap dates in preparation for next round of public comments.								1
1.004	The system shall 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
1.005	The system shall 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
1.006	CPOE Laboratory Data: The system shall provide practice customized, 2-way laboratory interfaces with companies like Lab Corp and Quest.									1

<i>Fully Interoperable EHR Totals:</i>	<i>Number of Requirements</i>	<i>EX</i>	<i>PL</i>	<i>MOD</i>	<i>CD</i>	<i>TP</i>	<i>CM</i>		<i>Missing/Invalid</i>
	9	0	0	0	0	0	0		9

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<i>Personal Health Record (PHR)</i>										
<i>105</i>	<i>Chronic Disease Management</i>	<i>Vendor's Response</i>								
<i>Number</i>	<i>Description</i>	<i>DMH Comment</i>	<i>EX</i>	<i>PL</i>	<i>MOD</i>	<i>CD</i>	<i>TP</i>	<i>CM</i>	<i>Vendor Comment</i>	<i>Missing/Invalid</i>
<b>5.006</b>	PHR: The system shall provide the ability to send information to a client for review via a personal health record (PHR).									1
<b>5.007</b>	PHR: The system shall provide two-way communication with the client via a PHR so that the client can receive messages from the provider and the client can send the practice requests for eRX refills, appointment scheduling, and inquiries.									1
<b>5.008</b>	PHR: The system shall provide the ability for the client to enter in their demographic, insurance information, family history, social history and prior medical history via a secured PHR website.									1
<b><i>Personal Health Record (PHR) Totals:</i></b>		<b><i>Number of Requirements</i></b>	<b><i>EX</i></b>	<b><i>PL</i></b>	<b><i>MOD</i></b>	<b><i>CD</i></b>	<b><i>TP</i></b>	<b><i>CM</i></b>		<b><i>Missing/Invalid</i></b>
		<b>3</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>		<b>3</b>

<i>Company Name:</i>								
<i>Vendor's Responses</i>								
<i>Requirement Category</i>	<i>Number of Requirements</i>	<i>Already Existing Functionality</i>	<i>Planned Within 12 Months</i>	<i>Would Require Software Modifications</i>	<i>Would Require Custom Development</i>	<i>Would Require Third Party Software</i>	<i>Cannot Meet Requirement</i>	<i>Missing/Invalid Responses</i>
<b>Infrastructure</b>	14	0	0	0	0	0	0	14
<b>Practice Management</b>	16	0	0	0	0	0	0	16
<b>Clinical Data</b>	20	0	0	0	0	0	0	20
<b>CPOE</b>	9	0	0	0	0	0	0	9
<b>Full EHR</b>	9	0	0	0	0	0	0	9
<b>PHR</b>	3	0	0	0	0	0	0	3
<b>Total</b>	71	0	0	0	0	0	0	71