

To select only criteria for AMB Add-On, filter column B to only include rows with value=YES



CCHIT Certified 2011 Behavioral Health EHR Certification Criteria
July 26, 2010

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N = New for Year
O = Provisional for 2011 (shaded in YELLOW)
R = Roadmap

Is this criterion included in the Add-on to AMB?	Criteria #	BH Category	Criteria	Year introduced or last modified	2011 Certification	Roadmap 1	Roadmap 2	Comments	Criteria Reference	Test Script Step Number
No	BH.001	Identify and Maintain a Patient Record	The system shall create a single patient record for each patient.	2011	N				AM 01.01	1.02
No	BH.002	Identify and Maintain a Patient Record	The system shall associate (store and link) key identifier information (e.g., system ID, medical record number) with each patient record.	2011	N			Key identifier information must be unique to the patient record but may take any system defined internal or external form.	AM 01.02	1.02
No	BH.003	Identify and Maintain a Patient Record	The system shall provide the ability to store more than one identifier for each patient record.	2011	N			For interoperability, practices need to be able to store additional patient identifiers. Examples include an ID generated by an Enterprise Master Patient Index, a health plan or insurance subscriber ID, regional and/or national patient identifiers if/when such become available.	AM 01.03	1.03
No	BH.004	Identify and Maintain a Patient Record	The system shall provide the ability to query for a patient by more than one form of identification.	2011	N				FN 02.01	1.03
No	BH.005	Identify and Maintain a Patient Record	The system shall provide a field which will identify patients as being exempt from reporting functions.	2011	O			The criterion relates to aggregate reporting and not to printing from the patient record. Examples may include patients who are deceased, transferred, moved, seen as consults only. Being exempt from reporting is not the same as de-identifying a patient who will be included in reports. De-identifying patients for reporting is addressed in the "Health record output" functionality. This criterion is PROVISIONAL for Stand-Alone certification in 2011.	AM 01.04	ADM.08, ADM.09
Yes	BH.005.1	Identify and Maintain a Patient Record	The system shall have the ability to capture a reason for exempting a patient from reporting functions.			R				
No	BH.006	Identify and Maintain a Patient Record	The system shall capture and maintain demographic information as discrete data elements as part of the patient record.	2011	N			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, regulatory, research and public health requirements will be included.	FN 01.02	1.02, 1.06
No	BH.007	Identify and Maintain a Patient Record	The system shall provide the ability to access demographic information such as name, date of birth and gender needed for patient care functions.	2011	N			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, regulatory, research and public health requirements will be included.	FN 01.01	1.03
No	BH.008	Identify and Maintain a Patient Record	The system shall provide the ability to modify demographic information about the patient.	2011	N				AM 02.04	1.06

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No	BH.009	Identify and Maintain a Patient Record	The system shall provide the ability to maintain and make available historic information for demographic data including prior names, addresses, phone numbers and email addresses.	2011	N			Providers need this for look up and contact purposes, e.g., when attempting to locate a patient or family member for clinical communications.	AM 02.02	1.07
No	BH.010	Identify and Maintain a Patient Record	The system shall provide the ability to merge patient information from two patient records into a single patient record.	2011	N			If a duplicate chart is created, information could be merged into one chart. Does not imply an unmerge capability. The intent is to merge information for a single patient; this would include discrete data elements from both patient records.	AM 01.05	1.04
No	BH.011	Manage Clinical Documents and Notes	The system shall provide the ability to create clinical documentation or notes (henceforth "documentation").	2011	N				AM 08.01	1.15
No	BH.012	Manage Clinical Documents and Notes	The system shall provide the ability to display documentation.	2011	N				AM 08.02	1.15
No	BH.013	Manage Clinical Documents and Notes	The system shall provide the ability to enter free text notes.	2011	N				AM 08.10	3.29
Yes	BH.014	Manage Clinical Documents and Notes	The system shall provide the ability to save assessments or any other work, such as treatment planning, in progress prior to finalizing.	2011	N				AM 08.03	1.28
Yes	BH.015	Manage Clinical Documents and Notes	The system shall provide the ability to finalize assessments or any other work that was saved in progress; i.e., change the status of the assessment or other work from in progress to complete, so that any subsequent changes are recorded as such.	2011	N				AM 08.04	1.33
No	BH.016	Manage Clinical Documents and Notes	The system shall provide the ability to record the identity of the user finalizing each note and the date and time of finalization.	2011	N			Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or finalize a clinical note. 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 criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.	AM 08.05	1.33
No	BH.017	Manage Clinical Documents and Notes	The system shall provide the ability to filter, search or order notes by the provider who finalized the note.	2011	N				AM 08.11	1.41
No	BH.018	Manage Clinical Documents and Notes	The system shall provide the ability to addend notes that have been finalized.	2011	N				AM 08.07	1.37
No	BH.019	Manage Clinical Documents and Notes	The system shall provide the ability to identify the full content of a modified note, both the original content and the content resulting after any changes, clarifications, addenda, etc. to a finalized note.	2011	N			This may be in the GUI or in the audit trail. It is adequate to be able to access pre- and post-modification versions of a note; i.e. it is not necessary for the system to have a single display that shows what modifications were made.	AM 08.08	1.38

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No	BH.020	Manage Clinical Documents and Notes	The system shall provide the ability to record and display the identity of the user who added a note and the date and time of the change.	2011	N				AM 08.09	1.37
Yes	BH.021	Manage Clinical Documents and Notes	The system shall support the use of electronic signatures.					R Medico-Legal. User rights are determined by role-based access defined in security. Only authorized users can complete, change or finalize a clinical note. 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 criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria may be introduced using such standards.		
Yes	BH.022	Manage Clinical Documents and Notes	The system shall provide the ability for multiple parties to sign a note and record the user ID and date and time of signature.	2011	N				AM 08.06	1.42
Yes	BH.151	Manage Clinical Documents and Notes	The system shall provide the ability to configure signature requirements based on document type and provider credentials.	2011	N					ADM.27
Yes	BH.152	Manage Clinical Documents and Notes	The system shall provide the ability to capture the signature from individuals without system access rights.	2011	N			For example, a guardian signing minor's treatment plan or probation officer indicating attendance at a meeting. This can be achieved by scanning in a signed piece of paper, digital signature, or other means.		2.22
Yes	BH.023	Manage Clinical Documents and Notes	The system shall provide the ability for signed notes to retain and display the identities of all providers who sign the note.	2011	N					1.43
No	BH.024	Manage Clinical Documents and Notes	The system shall provide the ability to document encounters by one or more of the following means: direct keyboard entry of text; 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.	2011	N			This does not preclude entry via new technologies.	AM 31.02	1.15
No	BH.025	Manage Clinical Documents and Notes	The system shall provide the ability to associate individual encounters with diagnoses.	2011	N				AM 31.03	2.08
No	BH.026	Manage Clinical Documents and Notes	The system shall have the ability to provide filtered displays of encounters based on encounter characteristics, including status, date of service, encounter provider and associated diagnosis.	2011	O			This criterion is PROVISIONAL for Stand-Alone certification in 2011.	AM 31.04	3.52
No	BH.027	Manage Clinical Documents and Notes	The system shall provide the ability to customize clinical templates.	2011	N				AM 08.20	ADM.03
No	BH.028	Manage Clinical Documents and Notes	The system shall provide the ability to capture other clinical data elements as discrete data.	2011	N			For example peak expiratory flow rate, size of lesions, severity of pain, suicide risk, functional impairments, depression scales, etc.	AM 08.16	3.05

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Yes	BH.029	Manage Clinical Documents and Notes	The system shall provide the ability to create, maintain and schedule groups for patients.	2011	N					2.24
Yes	BH.030	Manage Clinical Documents and Notes	The system shall provide the ability to automatically copy-forward notes for patients who have received a group service.	2011	N			For example, the provider may enter group process content, which will copy forward to individual patient notes. Specific patient content would then be added to each individual patient note before filing.		3.58
Yes	BH.153	Manage Clinical Documents and Notes	The system shall provide the ability to associate notes with treatment plan issues.	2011	N					2.08
Yes	BH.154	Manage Clinical Documents and Notes	The system shall provide the ability to allow organizations to define structured data for outcomes.	2011	N					ADM.02
No	BH.154	Manage Clinical Documents and Notes	The system shall provide the ability to allow organizations to define structured data for outcomes.	2011	O			This criterion is PROVISIONAL for Stand-Alone certification in 2011.		ADM.02
Yes	BH.155	Manage Clinical Documents and Notes	The system shall provide the ability to store and display data to and from an external personal health record including identifying that the data came from a personal health record.			R		For example, shared decision support, mood tracking, sleep logs, etc.		
No	BH.031	Patient History	The system shall provide the ability to capture, store, display, and manage patient history.	2011	N			Examples include past medical/surgical problems, diagnoses, procedures, family history and social history.	AM 06.01	1.19
No	BH.032	Patient History	The system shall provide the ability to capture structured data in the patient history.	2011	N			This function demonstrates the ability of a system to capture structured data but does not define the required elements of the patient history that shall be structured. Discrete data elements allow for searching and/or reporting by the EHR, and for this criterion the data could be free text or codified. Future functions would define the required patient history elements that shall be captured discretely as structured data, and where appropriate codified terminologies will be used.	AM 06.02	1.19
No	BH.033	Patient History	The system shall provide the ability to capture patient history as both a presence and absence of conditions, i.e., the specification of the absence of a personal or family history of a specific diagnosis, procedure or health risk behavior.	2011	N			Methods of capturing data as defined in BH.024.	AM 06.04	1.19
No	BH.034	Patient History	The system shall provide the ability to update a patient history by modifying or adding items in the patient history as appropriate.	2011	N				AM 06.03	1.37
No	BH.035	Patient History	The system shall provide the ability to capture history collected from outside sources.			R		This could include data from a personal health record, online patient histories, and information from pharmacy benefit management organizations.	AM 06.05	
Yes	BH.035.1	Patient History	The system shall provide the ability to identify information from an outside source and to capture and display the source of that outside information.			R				

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No	BH.036	Patient Clinical Measurements	The system shall provide the ability to capture patient vital signs, including blood pressure, heart rate, respiratory rate, height, and weight, as discrete data.	2011	N				Behavioral Health Functional Profile: DC.1.8.4 AM 08.13	3.11
Yes	BH.037	Advance Directives	The system shall provide the ability to indicate that a patient has completed medical advance directive(s) and/or mental health advance directive(s) and whether the advance directive(s) is available in the system.	2011	N			Important for appropriate use of resources at end of life and may just include a yes, no indication.	AM 16.01	3.02
No	BH.038	Advance Directives	The system shall provide the ability to indicate the type of advance directive(s), such as living will, durable power of attorney, or a "Do Not Resuscitate" order.	2011	N			This may be recorded in non-structured data or as discrete data.	AM 16.02	3.02
No	BH.039	Advance Directives	The system shall provide the ability to indicate when advance directives were last reviewed.	2011	N			This may be recorded in non-structured data or as discrete data.	AM 16.03	3.03
Yes	BH.040	Patient Preferences (Language, Religion, Culture)	The system shall provide the ability to capture, present, maintain and make available for clinical decisions patient preferences including but not limited to language, religion and culture.	2011	N				Behavioral Health Functional Profile: DC.1.3.1 DC.2.1.4	1.05
Yes	BH.041	Patient Preferences (Language, Religion, Culture)	The system shall provide the ability to capture, present, maintain and make available for clinical decisions family preferences such as language, religion and culture.			R			Behavioral Health Functional Profile: DC.1.3.1 DC.2.1.4	
Yes	BH.042	Patient Preferences (Language, Religion, Culture)	The system shall provide for the ability to capture and update patient and family preferences as they pertain to current treatment plans.				R		Behavioral Health Functional Profile: DC.1.3.1 DC.2.1.4	
Yes	BH.043	Patient Preferences (Language, Religion, Culture)	The system shall provide the ability to prompt the provider for testing and treatment options based on patient and family preferences and provide the ability to compare to standard practice as defined by the organization.				R		Behavioral Health Functional Profile: DC.1.3.1 DC.2.1.4	
Yes	BH.044	Patient Preferences (Language, Religion, Culture)	The system shall provide the ability to incorporate or link to preferences with appropriate teaching materials.			R			Behavioral Health Functional Profile: DC.1.3.1 DC.2.1.4	
Yes	BH.045	Legal Information	The EHR system shall provide the ability to define, record, track, and maintain historically, information about the legal status of a patient.	2011	N			Legal status could mean voluntary or involuntary, or could mean other things: court-ordered treatment and guardianship for example.		1.12
Yes	BH.046	Legal Information	The EHR system shall provide the ability to enter Guardian and/or Conservator information, as discrete data, including type, relationship to consumer, name, address, phone number, email address, court case number, court issued, effective date, and expiration date.	2011	N					1.25
Yes	BH.047	Legal Information	The EHR system shall provide the ability to enter multiple Guardians and/or Conservators for a patient and retain history.	2011	N					1.25
Yes	BH.049	Legal Information	The EHR system shall provide the ability to document events that are associated with the patient's current Legal Status.	2011	N			For example, meetings, hearings, document deadlines, or any other describable event.		1.14

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Yes	BH.051	Legal Information	The EHR system shall provide the ability to collect the necessary information if the care and treatment of the patient is legally required to be coordinated with or reported to a legal or law enforcement agency.	2011	N			Each state has different requirements for what is considered necessary information and should be defined by the user: for example, court orders, court dates.		1.12
Yes	BH.052	Assessments	The system shall provide the ability to create initial biopsychosocial assessments and document results.	2011	N			Examples of biopsychosocial assessments include but are not limited to: family history of mental illness, current and past substance use, current living situation.	Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	1.18
Yes	BH.053	Assessments	The system shall provide the ability to capture the results of standardized assessments tools.	2011	N				Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	1.15, 1.23
Yes	BH.054	Assessments	The system shall provide the ability to capture additional data to augment the standard assessment tools as appropriate.	2011	N				Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	ADM.03
Yes	BH.055	Assessments	The system shall provide the ability to include customized risk assessments as part of patient history documentation.	2011	N			For example, child abuse, elder abuse, fire setting risk assessments.		1.18
Yes	BH.056	Assessments	The system shall provide the ability to document, in discrete fields, information relating to the history of suicidal and other self-injurious behaviors and the assessment of current suicide risk.	2011	N					1.16
Yes	BH.057	Assessments	The system shall provide the ability to reference or include recognized national standards in standard suicide risk assessment documentation.			R		The work group will continue to review this and when a national standard is available the criterion will be placed on the roadmap accordingly.		
Yes	BH.058	Assessments	The system shall provide the ability to add additional comments and documentation to previously recorded Suicide risk assessments.	2011	N					1.14.01
Yes	BH.059	Assessments	The system shall provide the ability to include recognized national standards in standard homicide risk assessment documentation.				R	The work group will continue to review this and when a national standard is available the criterion will be placed on the roadmap accordingly.		
Yes	BH.061	Assessments	The system shall provide the ability to link data from external sources, laboratory results, and radiographic results to an assessment.				R	Dependent upon future standards; will continue to be reviewed by the Work Group.	Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	
Yes	BH.062	Assessments	The system shall provide the ability for the assessment data to populate the treatment plan.	2011	N			It is up to the user to define which elements of the assessment data will populate the treatment plan.	Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	2.06.02
Yes	BH.063	Assessments	The system shall provide the ability for the assessment data to populate the problem list.	2011	N					1.20
No	BH.063	Assessments	The system shall provide the ability for the assessment data to populate the problem list.	2011	O			This criterion is PROVISIONAL for Stand-Alone certification in 2011.		1.20
Yes	BH.064	Assessments	The system shall provide the ability to access assessment standards and practices. These may reside within the system or be provided through links to external sources.	2011	N				Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	1.22

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Yes	BH.065	Assessments	The system shall provide prompts based on practice standards to recommend additional assessment functions.			R			Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	
Yes	BH.066	Assessments	The system shall provide the ability to compare data against standardized curves and display trends.			R			Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	
Yes	BH.067	Assessments	The system shall provide the ability to compare elements of assessments captured by the clinician and those elements of assessments designated by the organization as best practice assessments and/or evidence based resources.				R	This item suggests posting best practices and/or evidence based resources for clinicians to review and compare, not that the system should automatically make the comparison.	Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	
No	BH.068	Assessments	The system shall provide the ability to capture certain physical history values as discrete data elements. The physical history capture must be fully customizable to meet the standards of the specific practice, however at a minimum, must include: past and present food and/or drug allergies, current medications, past and present physical status/diagnosis.			R		Examples of other fields that may be included are: blood pressure, height/weight/BMI, pregnancy status, head circumference, heart rate, etc. As nomenclature for any of these items is approved, this standard will require that any element added must comply with nomenclature and taxonomy standards so as to ensure interoperability.		
No	BH.069	Problem List	The system shall provide the ability to create and maintain a problem list.	2011	N			The problem list of a given individual can be described by formal coding systems (such as DRG's, NANDA Nursing Diagnosis, SNOMED, ICD9, DSM, etc.) or by other professional descriptions of health care issues affecting an individual. Problems can be short or long term in nature, chronic or acute, and have a status. In a longitudinal record, all problems may be of importance in the overall long term care of an individual, and may undergo changes in status repeatedly. Problems are identified during patient visits, and may span multiple visits, encounters, or episodes of care.	AM 03.01	1.20
Yes	BH.070	Problem List	The system shall provide the ability to display all current problems associated with a patient.	2011	N				AM 03.01	1.20
No	BH.071	Problem List	The system shall provide the ability to capture, maintain and display, as discrete data, free text comments associated with the problem / diagnosis.	2011	N				FN 04.01	1.18.01
No	BH.156	Problem List	The system shall provide the ability to associate orders, medications, and notes with one or more problems/diagnoses.	2011	N					1.45
No	BH.072	Treatment Plan	The system shall provide the ability to create and maintain site-specific care plans.	2011	N			This includes the use of clinical trial protocols to ensure compliance. It is expected that in the future discrete data elements from other areas of the chart will populate matching fields.	AM 17.02	ADM.04
Yes	BH.073	Treatment Plan	The system shall provide the ability to capture patient-specific plans of care and treatment.	2011	N				Behavioral Health Functional Profile: DC.1.6.2	2.13
Yes	BH.074	Treatment Plan	The system shall provide the ability to assign one or more individual providers to specific interventions within a treatment plan.	2011	N					2.14

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Yes	BH.157	Treatment Plan	The system shall provide the ability for multiple clinicians to update and modify a treatment plan.	2011	N					2.20
Yes	BH.075	Treatment Plan	The system shall provide the ability to make and track updates to a patient's plan of care and treatment including authors, dates, version history, responsible clinician, etc.	2011	N					2.12
Yes	BH.158	Treatment Plan	The system shall provide the ability to track progress towards the objectives.	2011	N					2.20
Yes	BH.076	Treatment Plan	The system shall provide the ability to use previously developed care plans as a basis for the creation of new plans of care and treatment.	2011	N				Behavioral Health Functional Profile: DC.1.6.2	2.06.01
Yes	BH.077	Treatment Plan	The system shall present guidelines and protocols for planning care and provide the ability to use and edit locally or non-locally developed templates, guidelines, and protocols for the creation of patient-specific plans of care and treatment.	2011	N				Behavioral Health Functional Profile: DC.1.6.2	2.06.03
Yes	BH.078	Treatment Plan	The EHR system shall have the ability to link completion of individual Treatment Plan components to a corresponding task in a provider's task list.			R			Behavioral Health Functional Profile: DC.3.1.2	
Yes	BH.159	Treatment Plan	The system shall provide the ability to allow the patient to review, indicate agreement or disagreement, and comment on the treatment plan.	2011	N					2.15
Yes	BH.160	Treatment Plan	The system shall provide the ability to prompt a clinician when treatment plan review is due and/or patient signature is required.	2011	N					2.21
Yes	BH.161	Treatment Plan	When a treatment plan item is assigned by one clinician to another clinician, the system shall create a notice and/or prompt for a signature as required by internal policy.	2011	N					2.25
No	BH.161	Treatment Plan	When a treatment plan item is assigned by one clinician to another clinician, the system shall create a notice and/or prompt for a signature as required by internal policy.	2011	O			This criterion is PROVISIONAL for Stand-Alone certification in 2011.		2.25
No	BH.080	Referrals	The system shall provide the ability to capture, store, display and manage referrals (both internal and external) with detail adequate for correct routing.	2011	N			This could include referrals to sub-specialists, physical therapy, speech therapy, nutritionists etc. Adequate detail includes but is not limited to: • Date • Patient name and identifier • "Refer to" specialist name, address and telephone number • "Refer to" specialty • Reason for referral • Referring physician name	AM 21.01	1.27
Yes	BH.250	Referrals	The system shall provide the ability to record referrals to and from other providers, transmit a confirmation back to the originating provider and to record the confirmation.			R				

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No	BH.081	Medication Management	The system shall provide the ability to capture medication administration details as discrete data, including: (1) the medication name and dose; (2) date and time of administration; (3) route and site; (4) lot number and expiration date; (5) manufacturer; and (6) user ID.	2011	N				FN 15.01	3.59
No	BH.084	Scheduling	The system shall provide the ability to display a schedule of patient appointments along with status, populated either through data entry in the system itself or through an external application interoperating with the system.	2011	N			Examples of status may include patient showed, patient cancelled, clinician cancelled, patient no-show.	AM 28.01	2.02
No	BH.085	Patient, Family and Caregiver Education	The system shall have the ability to incorporate or link to patient educational material, which may reside within the system or be provided through links to external sources.	2011	N				Behavioral Health Functional Profile: DC.3.2.4	1.30
Yes	BH.087	Patient, Family and Caregiver Education	The system shall provide the ability to use rules-based support to identify the most pertinent educational material, based on the patient health status, condition and/or diagnosis.				R		Behavioral Health Functional Profile: DC.3.2.4	
Yes	BH.088	Patient, Family and Caregiver Education	The system shall provide the ability to record the barriers to patient education.	2011	N				Behavioral Health Functional Profile: DC.3.2.4	1.29
Yes	BH.089	Patient, Family and Caregiver Education	The system shall provide the ability to document who received the educational material provided, the patient, and/or the patient representative, including date and time the materials were provided.	2011	N				Behavioral Health Functional Profile: DC.3.2.4	1.31
Yes	BH.090	Patient, Family and Caregiver Education	The system shall provide the ability to document that the educational material was reviewed with the patient and/or patient representative and their comprehension of the material and the date and time the material was reviewed.	2011	N				Behavioral Health Functional Profile: DC.3.2.4	1.32
No	BH.091	Manage Patient Grievances and Disputes	The system shall provide a means to document a patient's dispute with information currently in their chart.	2011	N			This does not imply that the patient can document directly in their chart. Some methods include but are not limited to allowing the patient a view only access to their record, printing a copy of the record for a patient to review. Methods to include the information in the chart could be as a note, a scanned copy of patient comments, an addendum to the note or other method not described.	AM 36.02	1.24
No	BH.092	Provider Management	The system shall provide the ability to capture and maintain identifiers required for licensed clinicians to support clinical practice.	2011	N			Examples include state medical license, NPI, DEA, etc.	AM 27.02	ADM.24
No	BH.093	Provider Management	The system shall provide the ability to maintain a directory of all clinical personnel who currently use or access the system.	2011	N				AM 27.01	SEC 5.04, 5.09
No	BH.094	Provider Management	The system shall allow authorized users to update the directory of clinical personnel who use or access the system.	2011	N				AM 27.03	SEC 5.41

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No	BH.095	Provider Management	The system shall provide the ability to create and maintain a directory of clinical personnel external to the organization who are not users of the system to facilitate communication and information exchange.	2011	O			This criterion is PROVISIONAL for Stand-Alone certification in 2011.	AM 27.04	ADM.25
No	BH.096	Manage Practitioner/Patient Relationships	The system shall provide the ability to capture and maintain, as discrete data elements, the principal provider responsible for the care of an individual patient.	2011	N				FN 03.02	3.04
Yes	BH.097	Manage Practitioner/Patient Relationships	The system shall provide the ability to capture and maintain, as discrete data elements, the identity of all providers associated with a patient, both within the agency and external to it.	2011	N				FN 03.01	1.44
No	BH.097	Manage Practitioner/Patient Relationships	The system shall provide the ability to capture and maintain, as discrete data elements, the identity of all providers associated with a patient, both within the agency and external to it.	2011	O			This criterion is PROVISIONAL for Stand-Alone certification in 2011.	FN 03.01	1.44
No	BH.098	Manage Practitioner/Patient Relationships	The system shall provide the ability to capture and maintain, as discrete data elements, the identity of all providers associated with a specific patient encounter.	2011	N			A provider is defined as anyone delivering clinical care such as physicians, PAs, CNPs and Nurses; the provider is the person who completes the note.	FN 03.01	ADM.23
No	BH.099	Manage Practitioner/Patient Relationships	The system shall provide the ability to specify the role or roles of each provider associated with a patient, such as encounter provider, primary care provider, attending, resident, or consultant using structured data.	2011	N			This is simply meant as a means to define the provider role. Display of that data is not addressed.	AM 34.02	3.04
Yes	BH.100	Clinical Decision Support	The rules based system shall provide the ability to support the development and maintenance of clinical toolkits and best practice standards as defined by the agency by prompting additional testing, possible diagnoses, or adjunctive treatment.				R		Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	
Yes	BH.101	Clinical Decision Support	The system shall provide the ability to compare patient context-driven assessments to best practices in order to identify patient specific growth or development patterns, health trends and potential health problems.				R		Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	
Yes	BH.102	Clinical Decision Support	The system shall provide the ability to compare assessment data entered during the encounter and the accessed health evidence based standards and best practices.				R		Behavioral Health Functional Profile: DC.1.5 DC.2.1.1-DC.2.1.3	
No	BH.103	Security and Access	The system shall provide the ability to identify certain information as confidential and only make that accessible by appropriately authorized users.	2011	N			This may be implemented by having a "confidential" section of the chart. In the future such confidential designation will be required at the data element level, e.g., individual problems on the problem list, medications, allergies, results, etc.	AM 36.04	3.16, 3.55
Yes	BH.104	Security and Access	The system shall restrict access to summarized information according to organizational policy, scope of practice, and jurisdictional law.				R	Check for overlap with Security and Privacy & Compliance criteria.	Behavioral Health Functional Profile: DC.1.1.4 S.3.3.6	

Is this criterion included in the Add-on to AMB?	Criteria #	BH Category	Criteria	Year introduced or last modified	2011 Certification	Roadmap 1	Roadmap 2	Comments	Criteria Reference	Test Script Step Number
No	BH.105	Security and Access	The system shall provide the ability to prevent specified user(s) from accessing a designated patient's chart.	2011	N			An example would be to block a user who has a personal relationship with a patient from accessing that patient's chart.	AM 36.05	1.46
Yes	BH.106	Security and Access	The system shall provide the ability to limit access to a patient's chart to providers directly involved in treatment of the patient, or providers involved in review of the treatment.	2011	N					2.27
No	BH.107	Security and Access	When access to a chart is restricted, the system shall provide a means for appropriately authorized users to "break the glass" for emergency situations.	2011	N				AM 36.06	1.47
No	BH.108	Security and Access	When access to a chart is restricted and the "break the glass" has occurred, the system shall provide the ability to audit this override.	2011	N					1.48
No	BH.109	Security and Access	The system shall provide the ability for concurrent users to simultaneously view the same record.	2011	N				AM 40.02	3.63
No	BH.110	Security and Access	The system shall provide the ability for concurrent users to view the same clinical documentation or template.	2011	N				AM 40.03	3.64
No	BH.111	Security and Access	The system shall provide the ability for multiple users to interact concurrently with the EHR application.	2011	N				AM 40.01	3.62
No	BH.112	Security and Access	The system shall provide protection to maintain the integrity of clinical data during concurrent access.	2011	N			To prevent users from simultaneously attempting to update a record with resultant loss of data	AM 40.04	3.65
No	BH.113	Confidentiality	The system shall have the ability to provide support for disclosure management in compliance with HIPAA and applicable law.	2011	N			This criterion may be satisfied by providing the ability to create a note in the patient's record. More advanced functionality may be market differentiators or requirements in later years.	AM 30.06	ADM.19
Yes	BH.114	Manage Terminology and Codes	The system shall provide the ability to support American Psychiatric Association's Diagnostic and Statistical Manual (DSM) codes.	2011	N				Behavioral Health Functional Profile: IN.4.1-IN.4.3 IN 4.2	1.18
Yes	BH.115	Manage Terminology and Codes	The system shall provide the ability to support Healthcare Procedure Coding System (HCPCS) codes.	2011	N				Behavioral Health Functional Profile: IN.4.1-IN.4.3 IN 4.2	ADM.29
Yes	BH.116	Manage Terminology and Codes	The system shall provide the ability to support International Classification of Diseases (ICD) codes.	2011	N					1.20
Yes	BH.117	Manage Terminology and Codes	The system shall allow customization of procedure and diagnostic codes to support organizational-specific codes.	2011	N			Map unique codes to billing codes.	Behavioral Health Functional Profile: IN.4.1-IN.4.3 IN 4.2	ADM.30
Yes	BH.118	Manage Terminology and Codes	The system shall provide the ability to support multiple versions of coding system defined by the organization.			R		Keeping prior versions of updated codesets for reference.		
Yes	BH.119	Manage Terminology and Codes	The system shall provide the ability to map customized codes to standardized terminologies or coding.	2011	N			For example, SNOMED, LOINC, CPT and HCPCS and local procedure codes		ADM.30
No	BH.120	Manage Terminology and Codes	The system shall have the ability to provide a list of financial and administrative codes.	2011	N			For example, ICD-9 CM, ICD-10 CM, and CPT-4 codes.	AM 32.01	ADM.21

Is this criterion included in the Add-on to AMB?	Criteria #	BH Category	Criteria	Year introduced or last modified	2011 Certification	Roadmap 1	Roadmap 2	Comments	Criteria Reference	Test Script Step Number
Yes	BH.121	Reporting/Data Exporting	The system shall provide the ability to generate hardcopy or electronic output of all of the individual patient's medical record.	2011	N			This could include but is not limited to the ability to generate standardized reports needed for work, school, or athletic participation.	AM 30.02	1.34
Yes	BH.122	Reporting/Data Exporting	The system shall provide the ability to generate hardcopy or electronic output of a user defined portion of the individual patient's medical record.	2011	N				AM 30.02	ADM.11
No	BH.123	Reporting/Data Exporting	The system shall provide the ability to generate hardcopy and electronic output by date and/or date range.	2011	N				AM 30.03	ADM.10
Yes	BH.124	Reporting/Data Exporting	The system shall provide the ability to report on any data elements that are held discretely.	2011	N			This includes using demographics to generate reports and also allows demographics to be gathered into a report.	AM 02.01	ADM.13
Yes	BH.125	Reporting/Data Exporting	The system shall provide the ability to add customized data fields, including required fields, as required to support reporting requirements.	2011	N			For example, documenting decisions based upon evidence-based practice		ADM.02, 1.26, 2.07
Yes	BH.126	Reporting/Data Exporting	The system shall support the use of third-party reporting tools through either direct access to the database or through exported data.	2011	N					ADM.07
No	BH.127	Reporting/Data Exporting	The system shall provide the ability to generate reports of clinical and administrative data using either internal or external reporting tools.	2011	N			Needed for pay for performance, quality improvement activities. All data that is entered in a structured format should be individually reportable.	AM 29.01	ADM.07
No	BH.128	Reporting/Data Exporting	The system shall provide the ability to define one or more reports as the formal health record for disclosure purposes.	2011	O			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. This criterion is PROVISIONAL for Stand-Alone certification in 2011.	AM 30.01	ADM.18
No	BH.129	Reporting/Data Exporting	The system shall provide the ability to create hardcopy and electronic report summary information (procedures, medications, labs, immunizations, allergies, and vital signs).	2011	O			The report that is produced should be organized by section to make it easier to read. This criterion is PROVISIONAL for Stand-Alone certification in 2011.	AM 30.05	ADM.12
No	BH.130	Reporting/Data Exporting	The system shall provide the ability to specify report parameters (sort and filter criteria) based on patient demographic and clinical data (e.g., all male patients over 50 that are diabetic and have a HbA1c value of over 7.0 or that are on a certain medication).	2011	N			Minimum demographic data are age and gender.	AM 29.04	ADM.07, ADM.14
No	BH.131	Reporting/Data Exporting	The system shall provide the ability to save report parameters for generating subsequent reports.	2011	O			This criterion is PROVISIONAL for Stand-Alone certification in 2011.	AM 29.07	ADM.15, ADM.17
Yes	BH.132	Reporting/Data Exporting	The system shall provide the ability to produce reports based on the absence of a clinical data element, including but not limited to: treatment plan not signed by patient; and expected assessment time frames.	2011	N				AM 29.06	ADM.16

Is this criterion included in the Add-on to AMB?	Criteria #	BH Category	Criteria	Year introduced or last modified	2011 Certification	Roadmap 1	Roadmap 2	Comments	Criteria Reference	Test Script Step Number
No	BH.132	Reporting/Data Exporting	The system shall provide the ability to produce reports based on the absence of a clinical data element, including but not limited to: treatment plan not signed by patient; and expected assessment time frames.	2011	O			This criterion is PROVISIONAL for Stand-Alone certification in 2011.	AM 29.06	ADM.16
Yes	BH.133	Reporting/Data Exporting	The system shall provide the ability to-report discrete numeric clinical data elements in tabular and graphical form.			R			AM 08.17	
No	BH.134	Reporting/Data Exporting	The system shall provide the ability to generate reports regarding multiple patients (e.g. diabetes roster).	2011	N			Any disease registry might be included.	AM 29.03	ADM.07
Yes	BH.135	Reporting/Data Exporting	The system shall be able to export all stored patient-related data			R		To support transitioning to a new system		
No	BH.136	Reporting/Data Exporting	The system shall provide the ability to export (extract) pre-defined set(s) of data out of the system.	2011	N			For example, export of performance measures, ability to query data base, chronic disease management tools.	AM 39.01	ADM.07
Yes	BH.138	Reporting/Data Exporting	The system shall be able to export data for Sentinel Events reporting as per developing national standards				R	For example, Suicide reporting		
Yes	BH.140	Reporting/Data Exporting	The system shall support the export of aggregate patient data for reporting use.			R				
No	BH.141	Capture External Documents	The system shall provide the ability to capture or import scanned paper consent documents.	2011	N			HL7 DC.1.1.3.1	AM 15.01	1.11
No	BH.142	Capture External Documents	The system shall provide the ability to store and display administrative documents (e.g. privacy notices).	2011	N			Needed for HIPAA. Scanned copy is acceptable for current year.	AM 15.04	1.08
No	BH.143	Data Retention, Availability and Destruction	The system shall provide the ability to retain data until otherwise purged, deleted, archived or otherwise deliberately removed.	2011	N				AM 37.01	SEC 6.11
No	BH.144	Data Retention, Availability and Destruction	The system shall provide a method for archiving health record information.			R			AM 37.02	
No	BH.145	Data Retention, Availability and Destruction	The system shall provide the ability to retrieve information that has been archived.			R		Retrieval does not imply restoration to current version of the software.	AM 37.03	
Yes	BH.146	Alerts and Notifications	The system shall provide the ability to support automated appointment reminders on upcoming patient appointments.			R		Method of notification is not specified.		
Yes	BH.147	Case Load	The system shall provide the ability to create and maintain a provider caseload.	2011	N					2.18
Yes	BH.148	Case Load	The system shall have the ability to assign an individual patient to more than one provider caseload.	2011	N					2.14
Yes	BH.149	Case Load	The system shall have the ability to restrict provider access to patients on the provider's caseload.	2011	N					2.19
Yes	BH.150	Case Load	The system shall provide the ability to transfer some or all of a provider's caseload to other care providers.	2011	N					2.23

Is this criterion included in the Add-on to AMB?	Criteria #	BH Category	Criteria	Year introduced or last modified	2011 Certification	Roadmap 1	Roadmap 2	Comments	Criteria Reference	Test Script Step Number
No	BH.252	Clinical Documentation	The system shall provide the ability to display HITSP C32/CCD documents and file them as intact documents in the EHR. Summary patient record content information will include: patient demographics, medication list and medication allergy list.	2011	O			Summary Documents Using CCD Component (HITSP v2.3 C32) Consumer Empowerment Interoperability Specification (HITSP v3.0 IS03) -OR- HITSP IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v.2.5 Summary Documents Using HL7 Continuity of Care Document (CCD); C80 v2.0 - Clinical Document and Message Terminology; C83 v2.0 - CDA Content Modules Requires the Document Consumer only to have the ability to display the document as requested. (it may not be able to locally import it in the patient record). This criterion is PROVISIONAL for Stand-Alone certification in 2011.	HITSP IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v.2.5 Summary Documents Using HL7 Continuity of Care Document (CCD); C80 v1.1 - Clinical Document and Message Terminology; C83 v1.1 - CDA Content Modules;	4.02
No	BH.254	Clinical Documentation	The system shall provide the ability to generate and format patient summary documents per the following specifications: HITSP C32 (v2.3 or v2.5) Summary patient record content information will include: patient demographics, medications and medication allergies. Generated xml documents must demonstrate use of industry-standard vocabularies/terminologies. The intent is to test the Required (R) fields including the product coded terminology for the medication and medication allergy.	2011	O			Summary Documents Using CCD Component (HITSP v2.3 C32) Consumer Empowerment Interoperability Specification (HITSP v3.0 IS03) -OR- HITSP IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v.2.5 Summary Documents Using HL7 Continuity of Care Document (CCD); C80 v2.0 - Clinical Document and Message Terminology; C83 v2.0 - CDA Content Modules This criterion is PROVISIONAL for Stand-Alone certification in 2011.	Summary Documents Using CCD Component (HITSP v2.3 C32) Consumer Empowerment Interoperability Specification (HITSP v3.0 IS03) -OR- HITSP IS107 v1.0 - EHR-Centric Interoperability Specification; CAP119 Communicate Structured Document Specification; C32 v.2.5 Summary Documents Using HL7 Continuity of Care Document (CCD); C80 v1.1 - Clinical Document and Message Terminology; C83 v1.1 - CDA Content Modules	4.03, 4.04, 4.05, 4.06
No	BH.168	Order medication	The system shall provide the ability to create prescription or other medication orders with sufficient information for correct filling and dispensing by a pharmacy.	2011	N			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.	AM 11.01	3.34, 3.51
No	BH.169	Order medication	The system shall provide the ability to create prescription or other medication orders with sufficient information for correct filling and dispensing by a pharmacy including entering dosing instructions in free text.				R	Example of dosing instructions is "pea-sized amount" for topical medications.	AM 11.01.01	
No	BH.170	Order medication	The system shall provide the ability to record user and date stamp for prescription related events, such as initial creation, renewal, discontinuation, and cancellation of a prescription.	2011	N				AM 11.02	3.34, 3.50
No	BH.171	Order medication	The system shall provide the ability to capture the identity of the prescribing provider for all medication orders.				R		AM 11.03	

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Yes	BH.172	Order medication	The system shall provide the ability to capture the original prescriber and indication, when the original prescriber is different than the current prescriber.			R				
No	BH.173	Order medication	The system shall provide the ability to capture common content for prescription details including strength, sig, quantity, and refills to be selected by the ordering clinician.	2011	N			We encourage the development of standard national abbreviations and that only approved abbreviations should be supported.	AM 11.04	3.34
No	BH.174	Order medication	The system shall provide the ability to receive and display information received through electronic prescription eligibility checking.			R		Will be required by e-prescribing. This criterion should maintain a record of whether the patient was eligible for coverage in the system.	AM 11.05	
No	BH.175	Order medication	The system shall provide the ability to reorder a prior prescription without re-entering previous data (e.g. administration schedule, quantity).	2011	N				AM 11.07	3.38
No	BH.176	Order medication	The system shall provide the ability to print and electronically fax prescriptions.	2011	N				AM 11.08	3.22, 3.35
No	BH.177	Order medication	The system shall provide the ability to re-print and re-fax prescriptions.	2011	N			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.	AM 11.09	3.23, 3.36
No	BH.178	Order medication	The system shall provide the ability to display a dose calculator for patient-specific dosing based on weight.			R		The intent is to allow input of dose-per-weight and patient weight and calculate the corresponding dose. The dose-per-weight might be directly inputted by a user at the time the dose calculation is to occur, or might have been inputted previously as the default for a particular medication. The output may be in terms that take into account a particular strength and dosage form of a medication (e.g. "5ml or "2 tablets") OR may be simply in terms of the amount of the active drug component (e.g. "250"). It is not required that the dose calculator automatically populate fields in the prescription itself.	AM 11.11	
No	BH.179	Order medication	The system shall provide the ability to identify medication samples dispensed, including lot number and expiration date.			R		Lot numbers and expiration date should be entered as discrete data.	AM 11.12	
No	BH.180	Order medication	The system shall provide the ability to prescribe fractional amounts of medication (e.g. 1/2 tsp, 1/2 tablet).	2011	N				AM 11.13	3.37
No	BH.181	Order medication	The system shall provide the ability to express dosing instructions in free text.	2011	N			For example, "pea-sized amount" for topical medications.	AM 11.13.01	3.33
No	BH.182	Order medication	The system shall provide the ability to alert the user if the drug interaction information is outdated.			R		The drug database should have an "expiration date" based on the frequency of their updates such that when that date has passed, the user is alerted. This criterion applies if the system requires user action to provide database updates as opposed to providing them automatically.	AM 11.14	

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No	BH.183	Order medication	The system shall provide the ability to allow the user to configure prescriptions to incorporate fixed text according to the user's specifications.	2011	N			This refers to the "written" output and language on the printed prescription such as practice address, practice telephone number, legally mandated text. For instance, users should be able to modify the format/content of printed prescriptions to comply with state Board of Pharmacy requirements.	AM 11.15	3.24, 3.28
No	BH.184	General Ordering Requirements	The system shall provide the ability to capture and maintain, as discrete data, a diagnosis/problem code or description associated with an order of any type (including prescriptions, medications ordered for administration, labs, and imaging).			R			FN 09.04	
No	BH.185	Order medication	The system shall provide the ability to display the associated problem or diagnosis (indication) on the printed prescription.			R		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.	AM 11.17	
No	BH.186	Order medication	The system shall provide the ability to create provider specific medication lists of the most commonly prescribed drugs with a default route, dose, frequency, and quantity.	2011	N				AM 11.19	3.31
No	BH.187	Order medication	The system shall provide the ability to add reminders for necessary follow up tests based on medication prescribed.	2011	N			Does not imply that this must be an automated process. It is acceptable if the system requires an action by the user, separate from the action of prescribing the medication, to configure the system to issue future reminders related to follow-up tests for the medication.	AM 11.20	3.41
No	BH.188	Order medication	The system shall provide the ability to automatically add reminders for necessary follow up tests based on medication prescribed.			R		As available through 3rd-party drug databases. Will be implemented when drug knowledge bases are ready to support this.	AM 11.21	
No	BH.189	Order medication	The system shall provide the ability for a user to select an order for a medication and exit the process of creating the order at some point prior to completion such that another user can access the order for subsequent review and completion.			R		The intent is to have the ability for one user to enter an order, place it in "pending" or similar status, so that a subsequent provider can complete and submit the order.	AM 11.22	
No	BH.190	Order medication	The system shall provide the ability to alert the user at the time a new medication is prescribed/ordered that drug interaction, allergy, and formulary checking will not be performed against the uncoded medication or free text medication.			R			FN 07.01	
No	BH.191	Order medication	The system shall provide the ability to prescribe/order uncoded and non-formulary medications.	2011	N				FN 07.02	3.33
No	BH.192	Order medication	The system shall provide the ability to maintain a coded list of medications including a unique identifier for each medication.	2011	N				FN 07.03	ADM.22

Is this criterion included in the Add-on to AMB?	Criteria #	BH Category	Criteria	Year introduced or last modified	2011 Certification	Roadmap 1	Roadmap 2	Comments	Criteria Reference	Test Script Step Number
No	BH.193	Order medication	The system shall provide end-users the ability to search for medications by generic or brand name.	2011	N				FN 07.04	3.21
No	BH.194	Order medication	The system shall provide the ability to access reference information for prescribing/ordering.			R		The reference information may reside within the system or be provided through links to external sources.	FN 07.05	
No	BH.195	Manage medication list	The system shall provide the ability to record the prescribing of medications including the identity of the prescriber.	2011	N				AM 04.02	3.34
No	BH.196	Manage medication list	The system shall provide the ability to maintain medication ordering dates.	2011	N				AM 04.03	3.21
No	BH.197	Manage medication list	The system shall provide the ability to maintain other dates associated with medications including start, modify, renewal and end dates as applicable.	2011	N				AM 04.04	3.21, 3.28, 3.37
No	BH.198	Manage medication list	The system shall provide the ability to display medication history for the patient.	2011	N			For clarification, medication history includes all medications prescribed since the EMR was established.	AM 04.05	3.40
No	BH.199	Manage medication list	The system shall provide the ability to capture medications entered by authorized users other than the prescriber.	2011	N			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 outside electronic interfaces from insurers, PBMs, etc. "User" means medical and non-medical staff who are authorized by policy to enter prescriptions or other documentation.	AM 04.06	3.40
No	BH.200	Manage medication list	The system shall store medication information in discrete data fields. At a minimum, there must be one field for each of the following: - medication name, form and strength; - dispense quantity; - refills; and - sig.	2011	N				AM 04.07	3.34
No	BH.201	Manage medication list	The system shall include standard medication codes associated with each medication in the list for medications in the vendor-provided medication database.			R		This criterion is intended to refer to nationally accepted standards for encoding medications when those become available and the specific standard would be stipulated in an interoperability criterion.	AM 04.08	
No	BH.202	Manage medication list	The system shall provide the ability to enter uncoded or free text medications when medications are not on the vendor-provided medication database or information is insufficient to completely identify the medication.	2011	N			Medications that are not on the vendor-provided medication database or not enough information is available to completely identify the medication. This could be either uncoded (Synthroid unknown dose) or free text (blue hypertension pill).	AM 04.09	3.32
No	BH.203	Manage medication list	The system shall provide the ability to enter or further specify in a discrete field that the patient takes no medications.	2011	N				AM 04.10	2.06
No	BH.204	Manage medication list	The system shall provide the ability to record the date of changes made to a patient's medication list and the identity of the user who made the changes.	2011	N			This information may appear as an optional view rather than a required view on the main screen. Need to capture the identity of the user and the date of changes made. Changes are to be recorded at the level of the individual medication.	AM 04.11	3.20

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No	BH.205	Manage medication list	The system shall provide the ability to indicate that a prescription's specified stop or end date has passed, OR automatically exclude from the display of current medications a prescription whose specified stop or end date has passed.			R			AM 04.12	
No	BH.206	Manage medication list	The system shall provide the ability to update and display a patient-specific medication list based on current medication orders and/or prescriptions.	2011	N				FN 06.01	3.30, 3.40, 3.51
No	BH.207	Manage medication list	The system shall provide the ability to display a current medication list.	2011	N				FN 06.02	3.18
No	BH.208	Manage medication list	The system shall provide the ability to exclude a medication from the current medication list (e.g. marked inactive, erroneous, completed, discontinued) and document reason for such action.	2011	N				FN 06.03	3.19
No	BH.209	Manage medication list	The system shall provide the ability to print a current medication list.	2011	N				FN 06.04	3.39
No	BH.210	Manage medication list	The system shall provide the ability to display that the patient takes no medications.	2011	N				FN 06.05	2.06
No	BH.211	Manage medication list	The system shall provide the ability to capture and maintain, as discrete data elements, all current medications including over-the-counter and complementary medications such as vitamins, herbs and supplements.	2011	N				FN 06.06	3.40
No	BH.212	Manage allergy and adverse reaction list	The system shall provide the ability to capture and store lists of medications and other agents to which the patient has had an allergic or other adverse reaction in a standard coded form.			R		Pending standard codes for allergens.	AM 05.01	
No	BH.213	Manage allergy and adverse reaction list	The system shall provide the ability to modify or inactivate an item on the allergy and adverse reaction list.	2011	N			This could include removal, marking as erroneous, or marking as inactive. "Remove" 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. Could include changing the type of reaction for a particular allergy.	FN 05.01	3.07
No	BH.214	Manage allergy and adverse reaction list	The system shall provide the ability to display information which has been inactivated or removed from the allergy and adverse reaction list.	2011	N				AM 05.03	3.13
No	BH.215	Manage allergy and adverse reaction list	The system shall provide the ability to distinguish between an allergy and an adverse reaction as discrete data.			R			AM 05.04 - revised	
No	BH.216	Manage allergy and adverse reaction list	The system shall provide the ability to specify the type of allergic or adverse reaction in a discrete data field.	2011	N				FN 05.04	3.09
No	BH.217	Manage allergy and adverse reaction list	The system shall provide the ability to capture and maintain, as discrete data, the identity of the user who added, modified, inactivated or removed items from the allergy and adverse reaction list, including attributes of the changed items. The user ID and date/time stamp shall be recorded.	2011	N			Attributes include the name of the allergen and the action (added, modified, inactivated or removed).	FN 05.05	3.10

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No	BH.218	Manage allergy and adverse reaction list	The system shall provide the ability for a user to explicitly capture and maintain, as discrete data, that the allergy list was reviewed. The user ID and date/time stamp shall be recorded when the allergies reviewed option is selected.	2011	N				FN 05.07	3.14, 3.15
No	BH.219	Manage allergy and adverse reaction list	The system shall provide the ability to explicitly indicate in a discrete field that a patient has no known drug allergies or adverse reactions.	2011	N				FN 05.09	2.05
No	BH.220	Manage allergy and adverse reaction list	The system shall provide the ability to display the allergy list, including date of entry.	2011	N			It must be possible for a user to view the date of entry for any allergy on the allergy list, but it is acceptable if that is viewed on another screen, e.g. a 'details' screen.	FN 05.12	3.12
No	BH.221	Manage allergy and adverse reaction list	The system shall provide the ability to capture, maintain and display, as discrete data, lists of medications and other agents to which the patient has had an allergic or other adverse reaction.	2011	N				FN 05.13	3.06, 3.08
No	BH.222	Request diagnostic tests	The system shall provide the ability to request diagnostic tests, including labs and imaging studies.	2011	N			This includes physicians and authorized non-physicians.	AM 12.01	3.17
No	BH.223	Request diagnostic tests	The system shall provide the ability to capture the identity of the requesting provider for all test requests.	2011	N				AM 12.02	3.17
No	BH.224	Request diagnostic tests	The system shall provide the ability to capture appropriate details of requests, including associated diagnosis.			R		Including associated diagnoses. It is desirable that all information for medical necessity checking be captured.	AM 12.03	
No	BH.225	Request diagnostic tests	The system shall provide the ability to display user created instructions and/or prompts when requesting diagnostic tests or procedures.			R		Refers to diagnostic test or procedure specific instructions and/or prompts; not patient 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.	AM 12.04	
No	BH.226	Request diagnostic tests	The system shall provide the ability to relay requests for a diagnostic test to the correct destination for completion.	2011	N			Mechanisms for relaying requests may include providing a view of the request, sending it electronically, or printing a copy of the request/requisition.	AM 12.05	3.17
No	BH.227	Request diagnostic tests	The system shall have the ability to provide a view of active requests for an individual patient with pending results.	2011	N			Additional sorts and filters may be provided by the vendors but not required.	AM 12.06	3.42
No	BH.228	Request diagnostic tests	The system shall have the ability to provide a view of requests by like or comparable type, e.g., all radiology or all lab requests.	2011	N			May include filters or sorts.	AM 12.07	3.46
No	BH.229	Request diagnostic tests	The system shall provide the ability to display outstanding requests for multiple patients (as opposed to outstanding requests for a single patient).	2011	O			A report may satisfy this criterion. Multiple patients may be defined as all patients in the organization or a subset. This criterion is PROVISIONAL for Stand-Alone certification in 2011.	AM 12.08	3.43
No	BH.251	Support for drug interaction	The system shall provide the ability to check for potential interactions between medications to be prescribed/ordered and current medications and alert the user at the time of medication prescribing/ordering if potential interactions exist.	2011	N				FN 12.01	3.25

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No	BH.230	Support for drug interaction	The system shall provide the ability to check for potential interactions between medications to be prescribed and medication allergies and adverse reactions listed in the record and alert the user at the time of medication prescribing/ordering if potential interactions exist.	2011	N				FN 12.10	3.48
No	BH.231	Support for drug interaction	The system shall provide the ability to check for potential interactions between medications ordered for administration (as opposed to prescriptions) and medication allergies and adverse reactions listed in the record and alert the user at the time of ordering if potential interactions exist.			R		'Ordered for administration' refers to administration at the site of care.	AM 19.02	
No	BH.232	Support for drug interaction	The system shall provide the ability to check for potential interactions between medications ordered for administration (as opposed to prescriptions) and current medications and alert the user at the time of ordering if potential interactions exist.			R		'Ordered for administration' refers to administration at the site of care.	AM 19.03	
No	BH.233	Support for drug interaction	The system shall provide the ability to set the severity level at which drug interaction warnings should be displayed.	2011	N				AM 19.05	ADM.26
No	BH.234	Support for drug interaction	The system shall provide the ability to view the rationale for a drug interaction alert.	2011	N				FN 12.05	3.26
No	BH.235	Support for drug interaction	The system shall provide the ability to capture and maintain at least one reason for overriding any drug-drug or drug-allergy/adverse reaction interaction warning triggered at the time of medication prescribing/ordering.	2011	N				FN 12.06	3.27, 3.50
No	BH.236	Support for drug interaction	The system shall provide the ability to enter a structured response when overriding a drug-drug or drug-allergy/adverse reaction warning.	2011	N				FN 12.07	3.27, 3.50
No	BH.237	Support for drug interaction	The system shall provide the ability to prescribe/order a medication despite alerts for interactions and/or allergies/adverse reactions being present.	2011	N				FN 12.08	3.28, 3.49
No	BH.238	Support for drug interaction	The system shall provide the ability to accept updates to drug interaction databases	2011	N				FN 12.09	SEC 6.27
No	BH.239	Medications / ePrescribing	The system shall provide the ability to send an electronic prescription to pharmacy	2011	N			Medication Management Interoperability Specification (HITSP v1.0 2008 IS07) X12 270/271/ CORE Phase I Rules	IO-AM 09.06	3.51, SEC 6.22.BH
No	BH.240	Medications / ePrescribing	The system shall provide the ability to send text or coded allergy information with new electronic prescriptions via constraints specified by the allergy segment of future NCPDP SCRIPT 10.x specifications.			R			IO-AM 09.07	
No	BH.241	Medications / ePrescribing	The system shall provide the ability to respond to a request for a refill sent from a pharmacy	2011	N			Transaction is now wide spread use so that systems that send new prescriptions need to be ready to respond to requests for refills.	IO-AM 09.09	SEC 6.22.BH
No	BH.242	Medications / ePrescribing	The system shall provide the ability to send a cancel prescription message to a pharmacy			R		Sent by the prescriber to cancel a prescription that was sent previously	IO-AM 09.10	

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No	BH.243	Medications / ePrescribing	The system shall provide the ability to respond to a request for a prescription change from a pharmacy -requires the ability to process an inbound Prescription Change Request (RXCHG) and generate an outbound Prescription Change Response (CHGRES)			R		Sent by the pharmacy to request that the prescriber make changes to a prescription before it is filled. Prescribing clinician must have the ability to view and respond to a request for a prescription change from a pharmacy.	IO-AM 09.11	
No	BH.244	Medications / ePrescribing	The system shall provide the ability to send electronic prescription to pharmacy including structured and coded SIG instructions			R		NCPDP SCRIPT v.10.5 references the Structured Sig Segment.	IO-AM 09.12	
No	BH.245	Medications / ePrescribing	The system shall provide the ability to send a query to verify prescription drug insurance eligibility and apply response to formulary and benefit files to determine coverage	2011	N			An essential first step prior to sending a query for medication history or formulary information directed at prescription drug coverage.	IO-AM 09.13	SEC 6.22.BH
No	BH.246	Medications / ePrescribing	The system shall provide the ability to capture and display formulary information from pharmacy or PBM (Pharmacy Benefits Manager) by applying eligibility response	2011	N			Usually preceded by a query for insurance eligibility to verify potential source of data.	IO-AM 09.14	SEC 6.22.BH
No	BH.247	Medications / ePrescribing	The system shall provide the ability to send a query for medication history to PBM or pharmacy to capture and display medication list from the EHR	2011	N			Used effectively during Medicare Part D pilots.	IO-AM 09.15	3.47, SEC 6.22.BH
No	BH.248	Medications / ePrescribing	The system shall provide the ability to receive medication fulfillment history from a pharmacy			R		Sent by pharmacy after medication has been dispensed to the patient. Compatible with HITSP IS07 which references HITSP T42 (Dispensing Status) which specifies SCRIPT 10.1 for applicability to Long-Term Care, but the CCHIT criterion predates HITSP's specification	IO-AM 09.16	
Yes	BH.249	Report Generation	The technology shall have the ability to report % patients at high risk for specified events who are on medications which reduce that risk.	2011	N					ADM.20
No	BH.249	Report Generation	The technology shall have the ability to report % patients at high risk for specified events who are on medications which reduce that risk.	2011	O			This criterion is PROVISIONAL for Stand-Alone certification in 2011.		ADM.20
No	SC 01.01	Access Control	The system shall enforce the most restrictive set of rights/privileges or accesses needed by users/groups (e.g. System Administration, Clerical, Nurse, Doctor, etc.), or processes acting on behalf of users, for the performance of specified tasks.	2011	N				ISO 17799: 9.1.1.2.b; HIPAA: 164.312(a)(1); 164.308(a)(3)(1) HITSP/TP20 NIST SP 800-53: AC-6 LEAST PRIVILEGE; AC-5 SEPARATION OF DUTIES	SEC 5.14, 5.15, 5.22, 5.25, 5.29
No	SC 01.02	Access Control	The system shall provide the ability for authorized administrators to assign restrictions or privileges to users/groups.	2011	N				Canadian: Alberta 4.1.3 (EMR); ISO 15408 CC SFR: FMT_MSA; NIST SP 800-53: AC-56 LEAST PRIVILEGE; AC-5 SEPARATION F DUTIES HIPAA: 164.312(a)(1); 164.308(A)(3)(1); HITSP/TP20	SEC 5.19

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No	SC 01.03	Access Control	The system must be able to associate permissions with a user using one or more of the following access controls: 1) user-based (access rights assigned to each user); 2) role-based (users are grouped and access rights assigned to these groups); or 3) context-based (role-based with additional access rights assigned or restricted based on the context of the transaction such as time-of-day, workstation-location, emergency-mode, etc.)	2011	N				Canadian: Ontario 5.3.12.e (System Access Management); ISO 15408 CC SFR: FDP_ACC, FMT_MSA; ASTM: E1985-98; NIST SP 800-53: AC-3 ACCESS AND INFORMATION FLOW CONTROL; SC-3 SECURITY FUNCTION ISOLATION HIPAA: 164.312(a)(1); 164.308(A)(3)(1); HITSP/TP20	SEC 5.10, 5.14, 5.15, 5.19, 5.22, 5.25, 5.29
No	SC 01.04	Access Control	The system shall support removal of a user's privileges without deleting the user from the system. The purpose of the criteria is to provide the ability to remove a user's privileges, but maintain a history of the user in the system.	2011	N				HIPAA: 164.308(a)(4)(ii)(C); 164.308(a)(3)(i)(C); HITSP/TP20	SEC 5.41, 5.43, 5.44, 5.46, 5.48, 5.49
No	SC 01.05	Access Control	If role-based access control (RBAC) is supported, the system shall be able to support role based access control that is in compliance with the HL7 Permissions Catalog.			R			HIPAA: 164.308(A)(3); HL7 Permissions Catalog, HITSP/TP20	
No	SC 01.06	Access Control	If role-based access control (RBAC) is supported, the system must be capable of operating within an RBAC infrastructure conforming to ANSI INCITS 359-2004, American National Standard for Information Technology – Role Based Access Control.			R			HIPAA: 164.308(A)(3); ANSI INCITS 359-2004, American National Standard for Information Technology - Role Based Access Control; HITSP/TP20	
No	SC 02.01	Audit	The system shall allow an authorized administrator to set the inclusion or exclusion of auditable events in SC 02.03 based on organizational policy & operating requirements/limits.	2011	N				ISO 15408 CC SFR: FAU_SEL; HIPAA 164.312(b); 164.308 (a)(1)(ii)(A), (D); Federal Register Response pages 8347, 8355; NIST SP 800-53 AU-2 AUDITABLE EVENTS (Organization Defined - Based on Risk Assessment) HITSP/TP15	SEC 5.53
No	SC 02.02	Audit	The system shall support logging to a common audit engine using the schema and transports specified in the Audit Log specification of IHE Audit Trails and Node Authentication (ATNA) Profile.	2011	N				NIST SP 800-92/SP 800-92, HITSP T15 HIPAA 164.312(a)(1); 164.312(b); 164.308 (a)(1)(ii)(A) and (D);	SEC 6.21

Is this criterion included in the Add-on to AMB?	Criteria #	BH Category	Criteria	Year introduced or last modified	2011 Certification	Roadmap 1	Roadmap 2	Comments	Criteria Reference	Test Script Step Number
No	SC 02.03	Audit	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 those listed in the <i>Appendix Audited Events</i> . 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.	2011	N				ISO 15408 CC SFR: FAU_GEN; NIST SP 800-53: AU-2 AUDITABLE EVENTS; HIPAA: 164.312(b); 164.312(1); 164.308 (a)(1)(ii)(A) and (D); HITSP/TP15	SEC 5.54
No	SC 02.04	Audit	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 patient identifier when relevant); (4) subject identity (e.g. user identity); and (5) the outcome (success or failure) of the event.	2011	N				ISO 15408 CC SFR: FAU_GEN; NIST SP 800-53: AU-3 CONTENT OF AUDIT RECORDS, AU-10 NON-REPUDIATION; HIPAA: 164.312(b); HITSP/TP15	SEC 5.55
No	SC 02.05	Audit	The system shall provide authorized administrators with the capability to read all audit information from the audit records in one of the following two ways: 1) The system shall provide the audit records in a manner suitable for the user to interpret the information. The system shall provide the capability to generate reports based on ranges of system date and time that audit records were collected. 2) The system shall be able to export logs into text format in such a manner as to allow correlation based on time (e.g. UTC synchronization).	2011	N			Assignable to third party.	ISO 15408 CC SFR: FAU_SAR; NIST SP 800-53: AU-7 AUDIT REDUCTION AND REPORT GENERATION; HIPAA: 164.312(b); HITSP/TP15	SEC 5.55, 7.14
No	SC 02.06	Audit	The system shall be able to support time synchronization using NTP/SNTP, and use this synchronized time in all security records of time.	2011	N			Assignable to third party.	ISO 15408 CC SFR: FPT_STM; NIST SP 800-53: AU-8 TIME STAMPS; HITSP/TP16 HIPAA: 164.312(b)	SEC 6.12, 7.18
No	SC 02.07	Audit	The system shall have the ability to format for export recorded time stamps using UTC based on ISO 8601. Example: "1994-11-05T13:15:30-05:00" corresponds to November 5, 1994, 8:15:30 am, US Eastern Standard Time.	2011	N				ISO 15408 CC SFR: FPT_STM; NIST SP 800-53: AU-8 TIME STAMPS; HITSP/TP15 HIPAA: 164.312(b)	SEC 5.56
No	SC 02.08	Audit	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.	2011	N			Assignable to third party.	ISO 15408 CC SFR: FAU_SAR, FAU_STG; NIST SP 800-53: AU-9 PROTECTION OF AUDIT INFORMATION; HIPAA: 164.312(a)(1); HITSP/TP15	SEC 5.15, 5.22

Is this criterion included in the Add-on to AMB?	Criteria #	BH Category	Criteria	Year introduced or last modified	2011 Certification	Roadmap 1	Roadmap 2	Comments	Criteria Reference	Test Script Step Number
No	SC 03.01	Authentication	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.	2011	N			Assignable to third party.	Canadian: Alberta 1.1; ISO 15408 CC SFR: FIA_UAU, FIA_UID; NIST SP 800-53: IA-2 USER IDENTIFICATION AND AUTHENTICATION; HIPAA: 164.312(d)	SEC 5.19, 5.24, 5.31, 5.36, 5.38, 5.43, 7.09
No	SC 03.02	Authentication	When passwords are used, the system shall support password strength rules that allow for minimum number of characters, and inclusion of alpha-numeric complexity.	2011	N			Assignable to third party.	Canadian: Alberta 7.3.12 (Security) Canadian Ontario 5.3.12.b (System Access Management); ISO 15408 CC SFR: FIA_SOS, FIA_UAU, FIA_UID; ASTM: E1987-98; NIST SP 800-53: IA-2 USER IDENTIFICATION AND AUTHENTICATION (no strength of password); ISO 17799: 9.3.1.d; HIPAA: 164.	SEC 5.11, 5.27, 5.32, 7.05
No	SC 03.03	Authentication	The system upon detection of inactivity of an interactive session shall prevent further viewing and access to the system by that session by terminating the session, or by initiating a session lock that remains in effect until the user reestablishes access using appropriate identification and authentication procedures. The inactivity timeout shall be configurable.	2011	N			Assignable to third party.	Canadian: Alberta 7.3.14 (Security) Canadian Ontario 5.6.12.a (Workstation Security); ISO 15408 CC SFR: FTA_SSL, FMT_SAE; NIST SP 800-53: AC-7 UNSUCCESSFUL LOGIN ATTEMPTS; AC-11 SESSION LOCK; AC-12 SESSION TERMINATION HIPAA: 164.312(a)(1); 164.312(a)(2)(iii)	SEC 5.26, 5.30, 5.31, 7.12
No	SC 03.04	Authentication	The system shall enforce a limit of (configurable) consecutive invalid access attempts by a user. The system shall protect against further, possibly malicious, user authentication attempts using an appropriate mechanism (e.g. locks the account/node until released by an administrator, locks the account/node for a configurable time period, or delays the next login prompt according to a configurable delay algorithm).	2011	N			Assignable to third party.	Canadian: Ontario 5.3.12.c (System Access Management); ISO 15408 CC SFR: FIA_AFL, FMT_SAE; NIST SP 800-53: AC-6 UNSUCCESSFUL LOGIN ATTEMPTS, AC-11 SESSION LOCK ; ISO 17799: 9.3.1.e, 9.5.2.e; HIPAA: 164.312(a)(1); 164.308(a)(5)(ii)C; 164.308(a)(6)	SEC 5.12, 5.34, 5.35, 5.36, 7.06
No	SC 03.05	Authentication	When passwords are used, the system shall provide an administrative function that resets passwords.	2011	N			Assignable to third party.	ISO 15408 CC SFR: FMT_MTD; ISO 17799: 9.2.3.b, (9.3.1.f); HIPAA: 164.312(d); 164.308(5)(ii)(D)	SEC 5.52, 7.15
No	SC 03.06	Authentication	When passwords are used, user accounts that have been reset by an administrator shall require the user to change the password at next successful logon.	2011	N			Assignable to third party.	ISO 15408 CC SFR: FMT_MTD; ISO 17799: 9.2.3.b, (9.3.1.f); HIPAA: 164.312(d); 164.308(5)(ii)(D)	SEC 5.58, 7.16

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No	SC 03.07	Authentication	The system shall provide only limited feedback information to the user during the authentication.	2011	N			Assignable to third party.	ISO 15408 CC SFR: FIA_UAU; NIST SP 800-53: IA-6 AUTHENTICATOR FEEDBACK; HIPAA: 164.312(d); 164.308(5)(ii)(D)	SEC 5.18, 5.20, 5.44, 7.08
No	SC 03.08	Authentication	The system shall support case-insensitive usernames that contain typeable alpha-numeric characters in support of ISO-646/ECMA-6 (aka US ASCII).	2011	N			Assignable to third party.	ISO 15408 CC SFR: FMT_MTD; HIPAA: 164.312(a)(2)(f)	SEC 5.24, 7.11
No	SC 03.09	Authentication	When passwords are used, the system shall allow an authenticated user to change their password consistent with password strength rules (SC 03.02).	2011	N			Assignable to third party.	ISO 15408 CC SFR: FMT_MTD; HIPAA: 164.308(a)(5)(ii)(D)	SEC 5.27, 5.32, 7.13
No	SC 03.10	Authentication	When passwords are used, the system shall support case-sensitive passwords that contain typeable alpha-numeric characters in support of ISO-646/ECMA-6 (aka US ASCII).	2011	N			Assignable to third party.	Canadian: Ontario 5.3.12 (b); NIST SP 800-63; HIPAA: 164.308(a)(5)(ii)(D)	SEC 5.17, 5.19, 5.24, 7.07
No	SC 03.11	Authentication	When passwords are used, the system shall use either standards-based encryption, e.g., 3DES, AES, or standards-based hashing, e.g., SHA1 to store or transport passwords.	2011	N			Assignable to third party.	Canadian: Ontario 5.3.12.a (System Access Management); ISO 15408 CC SFR: FCS_CKM; NIST SP 800-53: SC-12 CRYPTOGRAPHIC KEY ESTABLISHMENT AND MANAGEMENT; HIPAA: 164.312(e)(1); 164.308(a)(5)(ii)(D) FIPS PUB 197 FIPS PUB 140-2	SEC 6.18, 6.19, 7.23, 7.24
No	SC 03.12	Authentication	When passwords are used, 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").	2011	N			Assignable to third party.	ISO 15408 CC SFR: FMT_MTD; ISO 17799 9.5.4.f; HIPAA 164.312(d); 164.308(a)(5)(ii)(D); NIST SP 800-53: IA5 AUTHENTICATOR MANAGEMENT	SEC 6.01, 7.25
No	SC 03.13	Authentication	The system shall support two-factor authentication in alignment with NIST 800-63 Level 3 Authentication. Note: This is to support the 21 CFR Parts 1300, 1304, et al. Electronic Prescriptions for Controlled Substances; Proposed Rule published on Friday, June 27, 2008, Federal Register / Vol. 73, No. 125,F11.				R		ISO 15408 CC SFR: FIA_UAU; NIST SP 800-53: IA-2/AC-19, OMB M-06-16; NIST SP 800-63; HIPAA: 164.306(a)(1); 164.308(a)(4)(ii)(B); 164.308(a)(4)(ii)(C)	
No	SC 04.01	Documentation	The system shall include documentation that describes the patch (hot-fix) handling process the vendor will use for EHR, 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).	2011	N				ISO 15408 CC SFR: AGD_ADM; HIPAA: 164.308(a)(5)(f)(B)	SEC 6.07

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No	SC 04.02	Documentation	The system shall include documentation that explains system error or performance messages to users and administrators, with the actions required.	2011	N				ISO 15408 CC SFR: AGD_ADM; HIPAA: 164.312(c)	SEC 6.08
No	SC 04.03	Documentation	The system shall include documentation of product capacities (e.g. number of users, number of transactions per second, number of records, network load, etc.) and the baseline representative configurations assumed for these capacities (e.g. number or type of processors, server/workstation configuration and network capacity, etc).	2011	N				ISO 15408 CC SFR: AGD_ADM; NIST SP 800-53 CM-2; HIPAA: 164.312(c); 164.306(A)(1)	SEC 6.09
No	SC 04.04	Documentation	The system shall include documented procedures for product installation, start-up and/or connection.	2011	N				ISO 15408 CC SFR: ADO_IGS; HIPAA: 164.312(c)	SEC 6.06
No	SC 04.05	Documentation	The system shall include documentation of the minimal privileges necessary for each service and protocol necessary to provide EHR functionality and/or serviceability.	2011	N				NIST SP 800-53 AC-5 SEPARATION OF DUTIES; CM-7 Least Functionality; HIPAA: 164.312(a)(1); 164.312(a)(2)	SEC 6.05
No	SC 04.06	Documentation	The system shall include documentation available to the customer 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.).	2011	N				Canadian: Alberta 7.3.17 (Security); ISO 15408 CC SFR: FPT_TST ISO 15408 CC SFR: AGD_ADM; NIST SP 800-53 SI-3 MALICIOUS CODE PROTECTION; HIPAA: 164.308(a)(5)(i)(B)	SEC 6.03
No	SC 04.07	Documentation	If the system includes hardware, 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.	2011	N				ISO 15408 CC SFR: AGD_ADM; HIPAA: 164.310(a)(2)	SEC 6.04
No	SC 04.08	Documentation	The system shall include documentation that itemizes the services (e.g. PHP, web services) and network protocols/ports (e.g. HL-7, HTTP, FTP) that are necessary for proper operation and servicing of the system, including justification of the need for that service and protocol. This information may be used by the healthcare facility to properly configure their network defenses (firewalls and routers).	2011	N				ISO 15408 CC SFR: AGD_ADM; NIST SP 800-53 AC-5 CM-6; NIST SP 800-70; HIPAA 164.312(a)(1)	SEC 6.05
No	SC 04.09	Documentation	The system shall include documentation that describes the steps needed to confirm that the system installation was properly completed and that the system is operational.	2011	N				ISO 15408 CC SFR: AGD_ADM; HIPAA: 164.312©	SEC 6.06

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No	SC 04.10	Documentation	The system shall include documentation available to the customer that provides guidelines for configuration and use of the 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.	2011	N			Assignable to third party.	ISO 15408 CC SFR: AGD_ADM; HIPAA: 164.312(a) to 164.312(e)	SEC 5.04, 5.09, 6.02, 7.04
No	SC 05.01	Technical Services	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.	2011	N				ISO 15408 CC SFR: ADO_DEL; HIPAA 164.308(a)(5)(ii)(B)	SEC 6.11
No	SC 05.02	Technical Services	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.).	2011	N			Assignable to third party.	ISO 15408 CC SFR: FPT_RCV; HIPAA 164.312(c)(1)	SEC 6.10, 7.17
No	SC 06.01	Technical Services	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.	2011	N			Assignable to third party.	Canadian: Alberta 7.4.6.2 & 8.4.6.2 (Technical); ISO 15408 CC SFR: FCS_COP; FIPS 140-2; NIST SP 800-53: SC-13 CRYPTOGRAPHIC OPERATIONS; HIPAA: 164.312(e)(1); 164.312(a)(2)(iv) HITSP T17, FIPS PUB 140-2	SEC 6.14, 7.19
No	SC 06.02	Technical Services	When passwords are used, the system shall not display passwords while being entered.	2011	N			Assignable to third party.	ISO 15408 CC SFR: FPT_ITC; ISO 17799 9.2.3; HIPAA 164.312(a)(1)	SEC 5.20, 7.10
No	SC 06.03	Technical Services	For systems that provide access to PHI through a web browser interface (i.e. HTML over HTTP) shall include the capability to encrypt the data communicated over the network via SSL (HTML over HTTPS). Note: Web browser interfaces are often used beyond the perimeter of the protected enterprise network	2011	N			Assignable to third party.	ISO 15408 CC SFR: AGD_ADM; HITSP/TP17; HIPAA: 164.312(e)(1); 164.312(a)(2)(iv)	SEC 6.17, 7.22
No	SC 06.04	Technical Services	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.	2011	N			Assignable to third party.	ISO 15408 CC SFR: FPT_RCV; FIPS 140-2; SP800-53: SC-13 CRYPTOGRAPHIC OPERATIONS; HIPAA: 164.312(e)(1); HITSP T17	SEC 6.15, 7.20

Is this criterion included in the Add-on to AMB?	Criteria #	BH Category	Criteria	Year introduced or last modified	2011 Certification	Roadmap 1	Roadmap 2	Comments	Criteria Reference	Test Script Step Number
No	SC 06.05	Technical Services	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).	2011	N			Assignable to third party.	ISO 15408 CC SFR: FPT_RCV; HITSP T17; HIPAA: 164.312(d); 164.312(c)(1)	SEC 6.16, 7.21
No	SC 06.06	Technical Services	The system, when storing PHI on any device intended to be portable/removable (e.g. thumb-drives, CD-ROM, PDA, Notebook), shall support use of a standards based encrypted format using triple-DES (3DES), or the Advanced Encryption Standard (AES), or their successors.	2011	N				FIPS 140-2; ISO 15408 CC SFR: FCS_COP, OMB M-06-16, SP800-53: AC-19, HITSP T33; HIPAA: 164.312(e)(2)(ii) FIPS PUB 140-2	SEC 6.20, 7.26
No	SC 06.07	Technical Services	The system, prior to access to any PHI, shall display a configurable warning or login banner (e.g. "The system should only be accessed by authorized users"). In the event that a system does not support pre-login capabilities, the system shall display the banner immediately following authorization.	2011	N			Assignable to third party.	CC 2.1 L.4 TOE access banners (FTA_TAB); CC 3.0 FIA_TIN.1 Advisory warning message; NIST SP 800-53 AC-8 System Use Notification HIPAA 164.308(a)(5)(i); 164.308(a)(5)(ii)	SEC 5.13, 5.21
No	SC 07.01	Inter-Domain	The system shall be able to communicate identity information across domains and web services using standards based user authentication and access control.			R			HITSP/C19, ANSI INCITS 359-2004, American National Standard for Information Technology - Role Based Access Control, SAML v2.0; HIPAA 164.312(d)	
No	SC 07.02	Inter-Domain	When the system uses HITSP TP13 (IHE XDS) as a Document Consumer, the system shall be able to use the TP13 "Document Integrity" option. This may be a configurable parameter or may be enabled at all times			R			HITSP TP13 (IHE XDS); HIPAA 164.312(c)(1); 164.312(e)(1); 164.312(e)(2);	
No	SC 08.01	Backup/Recovery	The system shall be able to generate a backup copy of the application data, security credentials, and log/audit files.	2011	N			Assignable to third party.	Canadian: Alberta 7.3.16 (Security); ISO 15408 CC SFR: FDP_ROL, FPT_RCV; HIPAA: 164.310(d)(1)	SEC 5.01, 7.01
No	SC 08.02	Backup/Recovery	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.	2011	N			Assignable to third party.	Canadian: Alberta 7.3.18.9 (Security); ISO 15408 CC SFR: FAU_GEN; NIST SP 800-53: AU-2 AUDITABLE EVENTS; HIPAA: 164.310(d)(1)	SEC 5.06, 5.08, 7.03
No	SC 08.03	Backup/Recovery	If the system claims to be available 24x7 then the system shall have ability to run a backup concurrently with the operation of the application.	2011	N			Assignable to third party.	Canadian: Alberta 7.4.2.5 (Technica+D1); ISO 15408 CC SFR: FDP_ROL; HIPAA: 164.310(d)(1)	SEC 5.02, 7.02

Is this criterion included in the Add-on to AMB?	Criteria #	BH Category	Criteria	Year introduced or last modified	2011 Certification	Roadmap 1	Roadmap 2	Comments	Criteria Reference	Test Script Step Number
			Appendix Audited Events 1. start/stop 2. user login/logout 3. session timeout 4. account lockout 5. patient record created/viewed/updated/deleted 6. scheduling 7. query 8. order 9. node-authentication failure 10. signature created/validated 11. PHI export (e.g. print) 12. PHI import 13. security administration events 14. backup and restore							