

Primary Care Baseline

Requirements

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1. INTRODUCTION

1.1 Overview

The purpose of this document is to describe a common set of functional and non-functional requirements that are fundamental to a primary care healthcare setting.

Some of the functional requirements refer to the Ministry of Health (MOH) OHIP INFO Bulletins. OMD will make reasonable efforts to reference information received from the MOH on its website(s), however, readers are responsible for obtaining the necessary and most current information to continuously meet the Primary Care Baseline requirements. OMD shall not be responsible for the accuracy of the website links that are contained in this document or for any information contained on such websites. Respondents **MUST** contact the appropriate party to access the information needed if links to these websites are no longer available or if there is any doubt about their accuracy or currency.

Functional requirements **MUST** be in line with all legal requirements under Ontario Regulation 114/94 (Medicine Act, 1991) and all policies (including updates) described in CPSO Policies - Medical Records Management. This policy references various other legislative requirements, including those that may apply depending on the context within which a physician or clinician is practicing. Medical records are also a fundamental component of regulatory functions carried out by the CPSO under the authority of the Regulated Health Professions Act, 1991.

1.2 Scope of the EMR Baseline Requirements

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

1.2.1 Functional Requirements

- Demographic Management
- Electronic Medical Record (“EMR”) Management
- Immunization Management
- Medication Management
- Lab Test Management
- External Document Management
- Cumulative Patient Profile (CPP) Management
- Encounter Documentation Management
- Schedule Management
- Referral Management
- Reporting, Query and Communications
- Workflow Management
- Billing Management
- Interface Requirements

1.2.2 Non-functional Requirements

- Data Management
- Implementation Support
- Licensing

1.3 Version History

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

VERSION	REVISION DATE	NOTES
1.2	2020-09-13	<ul style="list-style-type: none"> a) Updated the Specification name (formerly “EMR Primary Care Requirements”) b) All references to the Ministry of Health and Long-Term Care (MOHLTC) have been updated to the Ministry of Health (MOH) c) Updated link to server hardening checklist d) Fixed cosmetic, formatting errors and errata e) Updated CPSO Policies - Medical Records link
1.3	2021-01-18	<ul style="list-style-type: none"> a) Removed section titled “Retired”. b) Updated EMR18.05 to reference the Health Card Validation Reference Manual more consistently. c) Updated EMR19.01 to include ISO 9001 certification as an option to substantiate patient safety within the quality management system.
1.4	2021-01-25	<ul style="list-style-type: none"> a) Removed Specification version in the document title
1.5	2021-09-10	<ul style="list-style-type: none"> a) Updated reference to OHIP Fee Schedule Master b) Moved privacy and security-related requirements out of this specification and into the Privacy and Security Specification c) Re-sequenced requirements: <ul style="list-style-type: none"> i. from EMR15.XX to EMR14.XX ii. from EMR17.XX to EMR15.XX iii. from EMR18.XX to EMR16.XX iv. from EMR19.XX to EMR17.XX d) Added Appendix B – Additional References section to reference related material for: <ul style="list-style-type: none"> i. Cumulative Preventive Care Bonus ii. Ontario's Routine Immunization Schedule e) Corrected various errata
1.6	2023-04-20	<ul style="list-style-type: none"> a) Changed REQ IDs to reflect Specification name (EMR###.## to PC##.##) b) Updated Additional References section: Information and Procedures for Claiming the Cumulative Preventive Care Bonus c) Corrected various errata
1.7	Mar 19, 2026	<ul style="list-style-type: none"> a) Revised the requirements with EMR Offering conformance language to standardize terminology, along with corresponding cosmetic refinements throughout the document. b) Revised the term ‘physician’ to ‘clinician’ where contextually appropriate throughout all requirements to align with a primary care clinic setting. c) Updated reference to Health Card Validation Reference Manual. d) Updated reference to Information and Procedures for Claiming the Cumulative Preventive Care Bonus. e) Updated reference to Interface to Health Care Systems Manual. f) Updated reference to Laboratory Requisition Form. g) Updated reference to Ontario's Routine Immunization Schedule. h) Updated PC01.01 to clarify the specific CDS section and removed the term ‘rostered’. i) Revised PC01.02 guidelines for greater clarity. j) Revised PC01.03 guidelines for greater clarity.

VERSION	REVISION DATE	NOTES
		<ul style="list-style-type: none"> k) Updated PC01.04 to provide greater clarity regarding 'contact purpose' and 'patient alternative contact'. l) Updated PC02.09, to accommodate the change from pap smear to HPV forms. m) Updated PC02.11 to provide greater clarity on patient's medical record tracking through 'audit log'. n) Revised PC03.01 by removing references to "yellow card" terminology. o) Revised PC03.03 for greater clarity on the applicability of drug database with DIN assignments by Health Canada. p) Updated PC04.01 to emphasize COTS solution for medication prescription. q) Revised PC04.03 to provide clarity on recording compounds, prescriptions with unknown DINs and associated content. r) Updated PC04.06 and PC04.07 for more clarity on commercial drug databases. s) Revised PC04.12 to provide greater clarity on 'Medication Summary'. t) Revised PC04.14 to provide greater clarity on COTS database 'license information'. u) Updated PC04.15 to clarify that vendors upgrade COTS drug database within two months of new version release. v) Revised wording of PC05.15 for greater clarity. w) Revised wording of PC05.16 for greater clarity. x) Added two new requirements, PC05.19 and PC05.20, to incorporate the launch of new HPV requisition forms and their working functionalities. y) Revised PC06.02 for greater clarity and relevant content. z) Revised PC07.13 for greater clarity. aa) Revised PC08.04 for greater clarity. bb) Revised PC08.05 for greater clarity. cc) Revised PC08.06 for greater clarity. dd) Revised PC09.06 for greater clarity on 'next available appointment search'. ee) Revised PC09.07 for greater clarity on printing the 'clinician schedule'. ff) Revised PC09.08 for greater clarity on printing 'day-sheet appointments.' gg) Revised PC09.09 for greater clarity and adding the guidelines. hh) Revised PC09.12 for greater clarity on 'ad-hoc double booking'. ii) Revised PC09.13 for greater clarity on 'appointment schedule view'. jj) Revised PC10.01 for greater clarity on 'referral letter' and removed references to templates. kk) Revised PC10.02 for greater clarity on 'referral letter list' and 'reminders.' ll) Updated PC11.02 for greater clarity and to accommodate the change from pap smear to HPV along with other updates. mm) Updated PC11.03 for greater clarity and recent changes. nn) Updated PC11.04 for greater clarity and recent changes. oo) Updated PC11.05 for greater clarity and recent changes. pp) Updated PC12.14 with sign-off feature relating to data integrity. qq) Updated PC14.03 by removing inapplicable and obsolete terminology related to database substantiation. rr) Revised PC16.01 with appropriate MCEDT terminology. ss) Updated PC16.03 for greater clarity. tt) Added PC17.02 to mandate an active support contract for any third-party software used in an EMR Offering.

1.4 Related Documents, References and Sources

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

DOCUMENT NAME	VERSION	PUBLICATION DATE
CPSO Medical Records Documentation (College of Physicians and Surgeons of Ontario, 2020) https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Medical-Records-Documentation	N/A	2020-03
CPSO Policies - Medical Records Management (College of Physicians and Surgeons of Ontario, 2022) https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Records-Management	NA	2022-03
Health Card Validation Reference Manual (Ministry of Health, 2024) https://www.ontario.ca/page/ohip-publications-medical-claims-and-health-card-validation	N/A	2024-10-02
Ontario Laboratory Requisition – Requisitioning Clinician/Practitioner (King’s Printer for Ontario, 2025) https://forms.mgcs.gov.on.ca/en/dataset/014-4422-84	N/A	2025-12
Ontario HPV and Cytology Requisitions – PCPs and Colposcopists 1) Screening Requisition and Instructions (for PCPs) i. English Requisition form: Human Papillomavirus (HPV) and Cytology Tests Requisition – For Cervical Screening ii. English Instructions form: How to complete the HPV and Cytology Tests Requisition – For Cervical Screening 2) Colposcopy Requisition and Instructions (for Colposcopists) i. English Requisition form: Human Papillomavirus (HPV) and Cytology Tests Requisition - Colposcopy for Follow-Up of Cervical Screening-Related Abnormalities ii. English Instructions form: How to complete the HPV and Cytology Tests Requisition – Colposcopy for Follow-Up of Cervical Screening-Related Abnormalities 3) Ontario Cervical Screening Program (OCSP) Cervical Screening Recommendations Summary - Ontario Health	N/A	N/A
OHIP INFO Bulletins (Ministry of Health, 2025) Search results for OHIP INFOBulletins ontario.ca	N/A	N/A
OHIP Fee Schedule Master (Ministry of Health, 2025) https://www.ontario.ca/page/ohip-schedule-benefits-and-fees#section-2	N/A	2025-10-03
OLIS Nomenclatures (Ontario Health)	Various	Various

DOCUMENT NAME	VERSION	PUBLICATION DATE
https://ehealthontario.on.ca/en/olis-nomenclature		
Ontario Regulation 114/94, Medicine Act, 1991 https://www.ontario.ca/laws/statute/91m30	N/A	2025-11-03
Processing Enrolment/Consent Forms Reference Manual for Primary Care Groups (Ministry of Health, 2011) Patient Enrolment Batch Header - Forms - Central Forms Repository (CFR)	N/A	2011-04
Physician's Guide to Third-Party and Other Uninsured Services (Ontario Medical Association, 2017) https://www.oma.org/ <i>Note: This is a "members only" document (found under the heading "Billing and Agreements")</i>	N/A	2017-01
Regulated Health Professions Act, 1991 https://www.ontario.ca/laws/statute/91r18	N/A	2025-11-03
Server Hardening Checklist (OntarioMD, 2011) https://www.ontariomd.ca/emr-certification/library/guides-and-references	N/A	2011-01-17
Technical Specifications – Interface to Health Care Systems Manual (Ministry of Health, 2023) https://www.ontario.ca/page/ohip-publications-medical-claims-and-health-card-validation MCEDT Reference Manual (May 2024) https://www.ontario.ca/files/2024-08/moh-ohip-mcedt-reference-manual-en-2024-08-20.pdf	6.2	2023-04-01

2. EMR REQUIREMENTS

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

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

Support:

M = Mandatory. EMR Offerings certified for this specification **MUST** support this requirement

O = Optional. EMR vendors **MAY** choose to support this requirement in their certified EMR Offering

Status:

N = New requirement for this EMR Specification version

P = Previous EMR requirement

U = Updated from the previous EMR Specification version

R = Retired from the previous version

OMD #:

A unique identifier that identifies each requirement within OMD's EMR Requirements Library.

CONFORMANCE LANGUAGE

The following definitions of the conformance verbs are used in this document:

- **SHALL/MUST**: Required/Mandatory
- **SHOULD**: Best Practice/Recommendation
- **MAY**: Acceptable/Permitted

The tables that follow contain column headings named: 1) "Requirement," which generally contain a high-level requirement statement; and 2) "Guidelines," which contain additional instructions or details about the high-level requirement. The text in both columns is considered requirement statements.

2.1 Demographic Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC01.01	The EMR Offering MUST maintain patient demographic data for patients.	Refer to the EMR Core Data Set Standard (CDS-S) Specification/ Patient Demographics section for patient demographic data elements.	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC01.02	The EMR Offering MUST support the assignment of a patient to the clinician's roster.	<p>Refer to the EMR CDS-S Specification/ Patient Demographics (DE01.015 - Primary Physician) for roster data elements.</p> <p>By assigning a patient to a "clinician roster" , the clinician becomes the "Primary Physician" / "Most Responsible Provider (MRP)" for the patient.</p> <p>IMPORTANT:</p> <p>The "rostering clinician", "primary physician" and "most responsible provider" terminology are used interchangeably within this document.</p> <p>In the context of the current requirement: "clinician" refers to a healthcare professional who provides direct patient care (e.g. physician, nurse practitioner, midwife, physical therapist, etc.)</p>	M	U
PC01.03	The EMR Offering MUST maintain the current and historical enrolment of a patient to a physician.	<p>Refer to the EMR CDS-S Specification / Patient Demographics (DE01.18 - DE01.22) for enrolment data elements.</p> <p>Patients rostered to a clinician can be either enrolled or non-enrolled to a physician.</p> <p>Patients are enrolled to a specific physician within a Physician Group and not to the Physician Group as a whole.</p> <p>The definitive patient enrolment to a physician, used for cumulative bonus payment, is kept by the MOH and not by the EMR Offering.</p> <p>For more information, refer to "Processing Enrolment/Consent Forms Reference Manual - for Primary Care Groups" in the Related Documents section.</p> <p>IMPORTANT:</p> <p>In the context of the current requirement "clinician" refers to a healthcare professional who provides direct patient care (e.g., physician, nurse, midwife, physical therapist, etc.)</p> <p>In the context of current requirement, Physician Group refers to clinics (e.g., FHO, FHT, etc.) where physicians are part of Ontario's Patient Enrollment Model.</p>	M	U
PC01.04	The EMR Offering MUST maintain multiple contacts for a patient, each associated with one or more purposes.	<p>Refer to the EMR CDS-S Specification / Patient Alternative Contact section for "patient alternative contact" data elements.</p> <p>A "patient alternative contact" is a person named by the patient as someone who should be contacted in specific situations by assigning "contact purpose."</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<p>The EMR Offering MUST support the assignment of multiple “contact purposes” (e.g., Substitute Decision Maker, Emergency Contact, Power of Attorney, etc.) to a “patient alternative contact”.</p> <p>At a minimum, the Substitute Decision Maker and Emergency Contact MUST be maintained for a “patient alternative contact”.</p> <p>Supporting assignment of only one “contact purpose” per “patient alternative contact” is not considered as an accepted EMR solution.</p>		
PC01.05	The EMR Offering MUST provide an automated method to identify and prevent duplication of patient records.	<p>The EMR Offering MUST support the functionality while:</p> <ul style="list-style-type: none"> a) Recording a new patient in the EMR b) Updating HCN (Health Card Number) in the EMR <p>At a minimum, the following parameters MUST be used to identify duplicate patients:</p> <ul style="list-style-type: none"> • HCN • Patient name (optional) <p>As patients may present Health Card Numbers issued by different authorities, the duplicate check should also incorporate the issuer as part of the identification criteria to support accurate patient matching without imposing geographic limitations.</p> <p>The HCN version code MUST be excluded from the matching criteria (function). An HCN with a different version code SHOULD be considered the same patient record.</p> <p>The EMR Offering MUST have the functionality to display an existing duplicate patient.</p>	M	U
PC01.06	The EMR Offering MUST support merging of duplicate patient records.	<p>Merging of patients refers to the merging of the entire patient medical record (not only patient demographics).</p> <p>Merging the duplicate records is a manual function controlled by the EMR user.</p> <p>Duplicate records automatically getting merged is not an acceptable solution.</p> <p>Prior to merging, the EMR user MUST be notified of the permanence of the action and given an opportunity to confirm the merging of duplicate patient records.</p> <p>Note: There is no requirement to undo the merge.</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC01.07	The EMR Offering MUST provide a means to access the patient's record by the patient's name and by the HCN.	Refer to Ontario Regulation 114/94 (Medicine Act, 1991), Section 20 (2).	M	U
PC01.08	The EMR Offering MUST maintain demographic data for providers.	Refer to the EMR CDS-S Specification for provider demographic data elements.	M	U

2.2 Electronic Medical Record (EMR) Management

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

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC02.08	The EMR Offering MUST maintain care element data.	<p>Refer to the EMR Chronic Disease Management Specification for chronic disease data elements.</p> <p>Refer to the EMR CDS-S Specification for generic care data elements.</p>	M	U
PC02.09	The EMR Offering MUST maintain the functionality to record and track preventive care screening/checkup activities over time.	<p>The EMR Offering MUST support tracking of the following preventive care screening / checkup activities for both Cumulative Bonus and Recall List Reports:</p> <ul style="list-style-type: none"> a) Mammogram Screening b) HPV Screening c) Colorectal Screening d) Childhood Immunization(s) e) Influenza Immunization <p>The EMR Offering MAY support additional tracking of the following preventive care screening / checkup activities. This list MAY change over time and is not limited to:</p> <ul style="list-style-type: none"> • Annual Physical Checkup (optional) • Pre-Natal Checkup (optional) • Well-Baby Checkup (optional) • Others <p>At a minimum, following data elements must be supported for each activity:</p> <ul style="list-style-type: none"> • Activity name • Activity date (e.g. procedure date, immunization date, etc.) • Notes • Due date (the next date the activity needs to be performed) (optional) 	M	U
PC02.10	The EMR Offering MUST automatically flag the past due preventive care screening/ checkup activities in the patient chart.	Flagged past due preventive care activities MUST be visually distinct in the patient chart and cannot be implemented through a work queue item (e.g. physician work queue, recall list report, etc.)	M	U
PC02.11	The EMR Offering MUST allow the modification of the patient's medical record to ensure accuracy in accordance with the CPSO Policy Statement on Medical Records.	<p>The intent of the requirement is to ensure accurate information informs care decisions and changes to the medical record are documented.</p> <p>Any information modified within the medical record MUST be available for the EMR user to review. The EMR Offering MUST track modifications to patient's medical records, including who made the change, and when the change was made in the audit log.</p> <p>The audit log MUST be available within the EMR Offering audit trail.</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<p>The EMR vendor is required to conform to all subsequent releases of the CPSO Medical Records Policy.</p> <p>Refer to the “Medical Records Documentation” section of the “CPSO Policies - Medical Records.”</p>		
PC02.12	The EMR Offering MUST enable the EMR user to know the status of the EMR data on a past date.	<p>At a minimum, the ability to know the status of past EMR data MUST be applied to the following data categories:</p> <ul style="list-style-type: none"> a) Ongoing Health Conditions data b) Past Medical and Surgical History data c) Allergy and Adverse Reaction data d) Family Medical History data e) Alerts and Special Needs data f) Immunization data g) Risk Factors data h) Care Elements data <p>The EMR user MUST be able to identify which information was known at the time a medical decision was made.</p> <p>Searching through the audit trail in order to find the status of patient data on a particular date DOES NOT satisfy the requirement.</p>	M	U

2.3 Immunization Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC03.01	The EMR Offering MUST provide the functionality to print the Immunization Summary for a patient.	<p>Immunization Summary MUST include:</p> <ul style="list-style-type: none"> a) Patient Name b) Patient Date of Birth c) Patient HCN d) Complete list of Patient’s Immunizations e) Immunization Date f) Name of the primary Clinician <p>In this context, “clinician” is the name of the clinician accountable for administering the specific vaccine(s) listed in the summary. As such, there may be more than one clinician name listed, if the patient had vaccinations administered by different clinicians.</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC03.02	The EMR Offering MUST integrate Immunization data recorded through EMR data fields across the EMR Offering.	Requiring the EMR user to re-enter immunization data to maintain Preventive Care, Chronic Disease Management, or any other current requirements involving immunization data is not an acceptable solution.	M	U
PC03.03	The EMR Offering SHOULD be able to automatically fill in the Immunization Type based on the selected Immunization Name and/or the Immunization Code (DIN-Drug Identification Number).	<p>The functionality is to automatically fill in the Immunization Type. This applies to EMR Offerings that use a COTS (commercial-off-the-shelf) drug database with Canadian drug codes (DIN) for the purpose of recording immunizations.</p> <p>In the context of this requirement, 'Immunization Code' refers to the unique identifier (DIN) assigned by Health Canada to drugs for marketing in Canada.</p>	O	U

2.4 Medication Management

The following terms are defined in this section:

- **Current Medications** – Medications that are part of the patient's treatment plan. This includes all active long-term and active short-term medications at the time of viewing the record.
- **Long-term Medications** – A medication that is expected to be continued beyond the present order and which the patient should be assumed to be taking unless explicitly stopped (also referred to as Continuous/Chronic). These are medications that the prescriber has identified as a part of the patient's ongoing treatment plan.
- **Short-term Medications** – A medication that the patient is only expected to consume for the duration of the current order, and which is not expected to be renewed (also referred to as Acute). These are medications the prescriber has not identified as part of the patient's long-term treatment plan.
- **Past Medications** – Medications that are no longer part of the patient's treatment plan.
- **PRN** – A medication that the patient will consume intermittently based on the behaviour of the condition for which the medication is indicated (also referred to as "As Needed"). Applies to both Long-term and Short-term Medications.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC04.01	The EMR Offering MUST provide the ability to record patient prescriptions using a publicly available COTS (commercial off-the-shelf) drug database with Canadian drug codes.	<p>Refer to the EMR CDS-S Specification/Medication section for medication/prescription data elements.</p> <p>At a minimum, the EMR Offering MUST use COTS for recording:</p> <ul style="list-style-type: none"> • Drug Name • Drug Strength / Drug Strength UM • Drug Form 	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<p>The EMR Offering MUST use a commercially licensed, COTS drug database, that provides:</p> <ul style="list-style-type: none"> • Health Canada–authorized drug information (e.g., DINs, approved products) • Clear licensing terms and accountability • Regular updates, maintenance, and technical support <p>Open-source drug databases that do not offer these assurances, not considered acceptable.</p>		
PC04.02	The EMR Offering MUST maintain a complete list of patient medications (Medication Summary).	<p>The complete list of patient medications MUST include:</p> <ol style="list-style-type: none"> Medications ordered by healthcare providers (both EMR and non-EMR users) Over-the-counter medications (without prescription) including herbal and nutritional supplements Past medications (that have not been recorded in the EMR) Current medications (prescriptions that are recorded EMR as a new order and/or refill order) <p>The medication record MUST:</p> <ul style="list-style-type: none"> • Identify whether medication was prescribed by internal clinician (EMR user) or external clinician (non-EMR user). • Display clinician’s name and designation for both internal and external clinicians. 	M	U
PC04.03	The EMR Offering MUST provide the ability to record patient prescriptions without using a publicly available COTS drug database (free-form text).	<p>Refer to the EMR CDS-S Specification / Medication section for medication / prescription data elements.</p> <p>This EMR functionality is required to support:</p> <ol style="list-style-type: none"> Recording of compounds Recording of prescriptions for which DIN is not known Recording prescription for the case when access to the COTS drug database is temporarily not available Other similar scenarios as applicable <p>"Free-form text" is for the purpose of prescribing custom compounds or complex prescriptions that are not supported by medication discrete data elements.</p> <p>IMPORTANT:</p> <p>The CDS-S defines the DE09.004- Drug Description discrete data element to support the recording of "free-form text" prescriptions and is the equivalent of DE09.003, which supports the recording of prescriptions using a COTS drug data database.</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC04.04	The EMR Offering MUST provide the functionality to create a pre-defined list of medications.	<p>The EMR Offering MUST support the creation of pre-defined list of medications at the EMR user level.</p> <p>The EMR Offering MAY support the creation of pre-defined list of medications:</p> <ul style="list-style-type: none"> Based on medical condition Based on patient 	M	U
PC04.05	The EMR Offering MUST provide clinicians with the functionality to print the prescription.	<p>Printed prescription MUST be able to include:</p> <ol style="list-style-type: none"> Clinician information (name, clinic address, phone number) Patient information (name, HCN, address, phone number) Name of medication Strength and strength unit Form Dosage Frequency Duration and/or quantity Refills Refill duration and/or refill quantity Start date Notes to pharmacist <p>It is acceptable that prescriptions are printed on a standard 8.5 x 11 sheets of paper.</p> <p>If the prescription spans multiple pages, all demographic info and clinician signatures MUST be printed on all pages.</p> <p>Multiple prescriptions can be printed on a single form.</p> <p>The EMR Offering MUST identify each user and the timestamp of the prescription when printed/re-printed. Accessing the audit log for this information is not an acceptable solution.</p>	M	U
PC04.06	The EMR Offering MUST perform drug-to-drug interaction using a publicly available COTS drug database with Canadian drug codes.	<p>For each identified drug-to-drug interaction, the EMR Offering MUST:</p> <ul style="list-style-type: none"> Indicate severity Allow override <p>Supporting an open-source drug database that doesn't include licensing, support and maintenance provisions is not an accepted solution.</p> <p>The EMR Offering MUST trigger drug-to-drug interaction only for "active prescriptions."</p> <p>IMPORTANT:</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		Severity is provided by COTS		
PC04.07	The EMR Offering MUST perform drug-to-allergy and drug-to-adverse reaction using a publicly available COTS drug database with Canadian drug codes.	<p>For each identified drug interaction, the EMR Offering MUST:</p> <ul style="list-style-type: none"> • Indicate severity • Allow override <p>Supporting an open-source drug database that doesn't include licensing, support and maintenance provisions is not an accepted solution.</p> <p>IMPORTANT:</p> <p>Severity is provided by EMR Offering as recorded in the EMR for the patient.</p>	M	U
PC04.08	The EMR Offering SHOULD perform an expanded drug-to-drug interaction using a publicly available COTS drug database with Canadian drug codes.	<p>The EMR Offering SHOULD indicate one or more of the:</p> <ol style="list-style-type: none"> a) Drug/condition interactions b) Drug/lab interactions c) Recommended dosage d) Therapeutic alternatives <p>Supporting an open-source drug database that doesn't include licensing, support and maintenance provisions is not an accepted solution.</p> <p>IMPORTANT:</p> <p>Severity is provided by COTS</p>	O	U
PC04.09	The EMR Offering MUST provide options to manage medication alerting for drug-to-drug interactions at the EMR user level.	<p>The EMR Offering MUST have the ability to set the threshold for the display of medication alerts at the EMR user level.</p> <p>Settings made at the EMR user level MUST supersede settings made at the organization level.</p> <p>Additional example workflows may include:</p> <ol style="list-style-type: none"> a) After the first time, a warning is presented to an EMR user, the user should be provided with the option to default that warning to "managed" in subsequent viewings. b) If a previously managed alert does not display, in the situation where medication information in the interaction database or the condition of the patient is updated, alerts previously defaulted to "managed" will retrigger. 	M	U
PC04.10	The EMR Offering SHOULD provide options to manage medication alerting for drug-to-	The EMR Offering SHOULD have the ability to set the threshold for the display of medication alerts at the organization level.	O	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
	drug interactions at the organizational level.	Additional example workflows may include: If a previously managed alert does not display, in the situation where medication information in the interaction database or the condition of the patient is updated, alerts previously defaulted to “managed” will retrigger.		
PC04.11	The EMR Offering SHOULD provide options to manage medication alerting for drug-to-drug interactions per patient, or per clinician.	The EMR Offering SHOULD have the ability to set the display of medication alerts per patient, or per clinician. Settings made per patient MUST supersede settings made at the clinician or organization level. Additional example workflows may include: If a previously managed alert does not display, in the situation where medication information in the interaction database or the condition of the patient is updated, alerts previously defaulted to “managed” will retrigger.	O	U
PC04.12	The EMR Offering MUST provide a Medication Summary view of the patient medication treatment plan.	At a minimum, the Medication Summary MUST display: a) Drug Name b) Start Date (or Written Date) c) Drug Strength (optional) d) Dosage (optional) The EMR Offering MUST: <ul style="list-style-type: none"> Be able to change the view between Active / Inactive / All medications (prescriptions) Group medications (prescriptions) by Drug Name and display the most current one with access to previous medications (prescriptions) within the group. The EMR Offering MUST display the medications (prescriptions) in reverse chronological order (most recent first) within each category. The EMR Offering MUST implement logic to identify whether a medication (prescription) is Active / Inactive based on: <ul style="list-style-type: none"> Start date (written date) / Duration / Refills/ etc. As manually flagged by the EMR user (optional) The EMR Offering MAY support additional views.	M	U
PC04.13	The EMR Offering MUST present dosage information over time for a medication selected by the EMR user in the patient’s medication list.	At a minimum, medication name, dosage, and start date MUST be displayed. The EMR user MUST be able to select any medication in the patient’s medication list.	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		Information MUST be printable. Printed information MUST include all data elements referenced in the requirement.		
PC04.14	The EMR Offering MUST provide the ability for an EMR user to view license information of the COTS drug database.	At a minimum, the following license information must be provided from the COTS drug database: a) name b) version # (optional) c) last update date Access to the COTS drug database MUST be from within the EMR Offering and MUST NOT require the EMR user to have administrative permissions (role) It is strongly recommended that this date is included within a centralized source of licensing information.	M	U
PC04.15	The EMR vendor MUST update the EMR Offering to the most recent COTS drug database version within 2 months of its release.	It is acceptable for the EMR vendors to notify and provide access to COTS drug database updates for customers to update their on-site EMR Offerings. IMPORTANT: This is applicable to both on-prem and hosted EMRs.	M	U
PC04.16	The EMR Offering MUST provide the ability to capture a refill quantity and refill duration (days' supply) which differs from the first dispensing.	Refer to the EMR CDS-S Specification for medication data elements.	M	U

2.5 Lab Test Management

The following terms are defined for this section:

- **Test Report** means a response from one laboratory at one date/time concerning one patient. A Lab Test Report may contain several Lab Test Results.
- **Test Result** means a single result of a single laboratory test.

For commercial laboratory interface requirements, refer to the Interface Requirements section.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC05.01	The EMR Offering MUST provide the ability to maintain laboratory test results as separate data fields.	Refer to the EMR CDS-S Specification for laboratory test data elements.	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC05.02	The EMR Offering MUST provide a visually distinct method of indicating new laboratory test reports through the clinician work queue and the patient chart.	New test reports are those that the clinician has received and has not yet opened and/or viewed. At a minimum, the functionality MUST be available to: <ul style="list-style-type: none"> The ordering clinician Copied-to clinician(s) 	M	U
PC05.03	The EMR Offering MUST provide a visually distinct indication of abnormal laboratory test reports through a clinician work queue and the patient chart.	At a minimum, test reports MUST: <ul style="list-style-type: none"> Display an 'abnormal' flag without opening the actual result. Be "sortable" such that after being sorted, abnormal lab reports appear at the top of the list. 	M	U
PC05.04	The EMR Offering MUST provide a visually distinct indication of which laboratory test result(s) are abnormal within a test report.		M	U
PC05.05	The EMR Offering MUST allow the EMR user to select a laboratory test name and graphically present its test results and reference ranges over time.	The graph MUST show: <ol style="list-style-type: none"> Test Name Test Result Value Reference Ranges Collection Date (if available) Scales MUST be appropriate to the data. The graph MUST be printable. The printed graph MUST include all data elements referenced in the requirement.	M	U
PC05.06	The EMR Offering SHOULD display, EMR user-selected patient medications, or other interventions, as data points, directly on the graph identified in OMD # PC05.05.	The use of mouse hovering or tool tips does not meet the requirement. The printed graph SHOULD include all data elements referenced in the requirement.	O	U
PC05.07	The EMR Offering MUST allow the EMR user to select a laboratory test name and present laboratory test results over time, in a table format.	The table MUST show: <ol style="list-style-type: none"> Test Name(s) Test Results Values Collection Date (if available) The table MUST be printable. The printed table MUST include all data elements referenced in the requirement.	M	U
PC05.08	The EMR Offering SHOULD print lab summaries and explanations for patients in lay terms, or in language that is	A lab summary is a printed summary of test results in tabular or graphical format, grouped by Test Name. An explanation can be provided via the clinician appending notes through the EMR Offering, or via	O	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
	easy for the patient to understand.	templates that are specific to the test names on the lab summary.		
PC05.09	The EMR Offering MUST support the scanning of laboratory test reports with the ability to indicate the lab reports with abnormal results.	EMR Offering MUST provide a visually distinct indication of abnormal scanned laboratory reports through a clinician work queue and the patient chart.	M	U
PC05.10	The EMR Offering MUST support adding annotations by the clinician that are tied to each laboratory test report and test result.	These are free-form text notes added by the clinician at the overall test report level and test result level (refer to Core Data Set Standard Data Element “DE10.017 – Physician Notes”).	M	U
PC05.11	The EMR Offering MUST be capable of reconciling laboratory test results with orders so that outstanding laboratory tests can be identified.	<p>The EMR user MUST be able to simultaneously view and compare the ordered and received lists of laboratory tests.</p> <p>Reconciliation may be automatic, manual, or a combination of both.</p> <p>Some lab orders may exist without matched results (i.e., the patient did not go to a lab). The EMR Offering MUST provide the ability to remove an order from the reconciliation list if desired.</p>	M	U
PC05.12	The EMR Offering MUST associate laboratory test reports/results with a specific patient record.	<p>Relates to any laboratory tests results received by the EMR Offering:</p> <ul style="list-style-type: none"> a) Through an interface b) Scanned into the EMR Offering c) Manual entry 	M	U
PC05.13	The EMR Offering MUST incorporate a functionality that allows the EMR user to cross-reference the EMR Offering’s proprietary test names to the test codes/test names from different laboratory proprietary standards.	Mapping of test codes to test names in the EMR Offering may be provided by the EMR vendor, or the EMR Offering MUST provide the ability for an EMR user to perform this mapping manually.	M	U
PC05.14	The EMR Offering MUST incorporate a functionality that allows the EMR user to cross-reference the EMR Offering’s proprietary test names to the LOINC Codes as specified in the OLIS Nomenclature.	Refer to the “OLIS Nomenclatures” in the Related Documents section.	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC05.15	The EMR Offering MUST have the functionality to complete the Ontario-Laboratory requisition form electronically.	<p>The EMR Offering MUST support:</p> <ul style="list-style-type: none"> a) Checking off appropriate boxes b) Adding text entries within the appropriate sections c) Location for clinician signature (wet signature) <p>The creation/compilation of the requisition form within the EMR Offering does not require a preview of the completed requisition form, but the laboratory tests requested, and the date/time of the laboratory requisition MUST be maintained in the EMR Offering within the patient chart.</p> <p>The EMR Offering MUST have the functionality to:</p> <ul style="list-style-type: none"> • Allow multiple updates to the laboratory requisition during the patient visit • Preserve the integrity of the original laboratory requisition that was completed (filled in) during the patient visit (changes made by the EMR user after patient visit MUST NOT affect the original laboratory requisition) <p>IMPORTANT:</p> <p>EMR Offerings are required to conform to the most recent updates.</p> <p>Refer to the “Laboratory Requisition” in the Related Documents section for the most current laboratory requisition form available.</p> <p>The standard Ontario - Laboratory Requisition form MAY be updated at MOH discretion.</p>	M	U
PC05.16	The EMR Offering MUST automatically populate the requester and patient metadata in the appropriate fields on the Ontario-Laboratory requisition form.	<p>The EMR Offering MUST have the functionality to:</p> <ul style="list-style-type: none"> a) Print out a completed requisition form. b) Provide real-time notifications to EMR users when mandatory requester or patient demographic information is missing. The notification MUST clearly identify all missing data elements and allow the user to either abort printing or continue with printing; both actions MUST be supported. <p>Refer to the “Laboratory Requisition” in the Related Documents section for the most current laboratory requisition form available.</p> <p>IMPORTANT:</p> <p>EMR Offerings are required to conform to the most recent updates.</p> <p>The standard Ontario - Laboratory Requisition form MAY be updated at MOH discretion.</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		The laboratory requisition form may be updated at the MOH's discretion. EMR Offerings are required to conform to the most recent update.		
PC05.17	The EMR Offering MUST allow laboratory test report(s) / result(s) to be received and associated with a patient record without requiring the creation of a laboratory requisition.	The lab result needs to be received and associated with a patient record without the manual or automated creation of a lab requisition.	M	U
PC05.18	The EMR Offering MUST be able to manage partial laboratory test reports in a manner that does not clutter the medical record.	<p>The default view is the most recent report received in the patient chart.</p> <p>The EMR user MUST be able to identify the annotations related to any test reports and test results, both partials and final.</p>	M	U
PC05.19	<p>The EMR Offering MUST have the functionality to allow EMR users to complete the Ontario - HPV and Cytology Screening Requisition forms:</p> <p>a) HPV and Cytology - For Cervical Screening</p> <p>b) HPV and Cytology - Colposcopy for Follow-Up of Cervical Screening -Related Abnormalities</p>	<p>The EMR Offering MUST support:</p> <ol style="list-style-type: none"> Checking off appropriate boxes, Adding text entries within the appropriate sections Location for clinician signature (wet signature or eSignature) Launching of the OSCP-recommendations from within the requisition form (NOTE: link specific to each form; included in the print-out) Launching of the HPV Instructions from within the requisition form (NOTE: link specific to each form; NOT included in the print-out) <p>The creation/compilation of the requisition form within the EMR Offering does not require a preview of the completed requisition form, but the screening tests requested, and the date/time of the screening requisition MUST be maintained in the EMR Offering within the patient chart.</p> <p>The EMR Offering MUST have the functionality to:</p> <ul style="list-style-type: none"> Allow multiple updates to the screening requisition during the patient visit Preserve the integrity of the original screening requisition that was completed (filled in) during the patient visit (changes made by the EMR user after patient visit MUST not affect the original screening requisition) <p>NOTE: Inaccurate or incomplete screening requisition can result in testing delays or rejection of the specimen.</p>	M	N

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<p>IMPORTANT:</p> <p>EMR Offerings are required to conform to the most recent updates.</p> <p>Refer to the Related Documents section for a link to the most current Ontario - HPV and Cytology Screening Requisition forms / OCSP-recommendations / HPV Instructions.</p> <p>The standard Ontario - HPV and Cytology Screening Requisition forms MAY be updated at MOH discretion.</p>		
PC05.20	The EMR Offering MUST automatically populate the requester and patient metadata in the appropriate fields on the Ontario- HPV Screening Requisition forms.	<p>The EMR Offering MUST have the functionality to:</p> <ul style="list-style-type: none"> a) Print out a completed requisition form. b) Provide real-time notifications to EMR users when mandatory requester or patient demographic information is missing. The notification MUST clearly identify all missing data elements and allow the user to either abort printing or continue with printing; both actions MUST be supported. <p>IMPORTANT:</p> <p>EMR Offerings are required to conform to the most recent updates.</p> <p>Refer to the Related Documents section for a link to the most current Ontario - HPV and Cytology Screening Requisition forms / OCSP-recommendations / HPV Instructions.</p> <p>The standard Ontario - HPV and Cytology Screening Requisition forms MAY be updated at MOH discretion.</p> <p>NOTE: Inaccurate or incomplete screening requisition can result in testing delays or rejection of the specimen.</p>	M	N

2.6 External Document Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC06.01	The EMR Offering MUST be able to import external reports (documents) to become a part of the EMR Offering.	<p>Refer to the EMR CDS-S Specification/section for external report data elements.</p> <p>Relates to any external document received by the EMR Offering:</p> <ul style="list-style-type: none"> a) Through an interface (e.g., HRM) b) Scanned into the EMR Offering (e.g., lab reports, special assessments etc.) <p>Copying and pasting the text from the original document into the EMR would not meet the requirement.</p>	M	U
PC06.02	The EMR Offering MUST provide the functionality to associate external reports (documents) with the appropriate patient record.	<p>Association between an external report and a patient MUST occur:</p> <ul style="list-style-type: none"> a) Manually, for external reports that are scanned and attached to a selected patient. b) Automatically, for external reports received through an interface, based on the patient-matching criteria defined for that interface. <p>External reports (documents) associated with a patient MUST be displayed in the patient chart, even if they have not been viewed and/or signed off by the clinician to whom the report has been assigned.</p>	M	U

2.7 Cumulative Patient Profile (CPP) Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC07.01	The EMR Offering MUST display Cumulative Patient Profile (CPP), identifying the summary of patient information.	<p>At a minimum, the CPP MUST display the following categories:</p> <ul style="list-style-type: none"> a) Ongoing Health Conditions b) Past Medical and Surgical History c) Family Medical History d) Immunization Summary e) Allergies and Adverse Reactions f) Medication Summary g) Risk Factors h) Medical Alerts and Special Needs <p>Refer to requirements PC07.02 through PC07.08 regarding CPP categories.</p> <p>Refer to the “CPSO Policies - Medical Records” for information about the CPP.</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC07.02	The EMR Offering MUST display ongoing health conditions.	Referenced also as ongoing (current) Health Condition or Diagnosis List. Refer to OMD EMR Core Data Set Standards (CDS-S) – Data Dictionary	M	U
PC07.03	The EMR Offering MUST display past medical and surgical history.	Refer to OMD EMR Core Data Set Standards (CDS-S) – Data Dictionary	M	U
PC07.04	The EMR Offering MUST display family medical history.	Refer to OMD EMR Core Data Set Standards (CDS-S) – Data Dictionary	M	U
PC07.05	The EMR Offering MUST display allergies and adverse reactions.	Refer to OMD EMR Core Data Set Standards (CDS-S) – Data Dictionary	M	U
PC07.06	The EMR Offering MUST display medications summary.	MUST display an ongoing medication treatment plan as the default. It MAY also include current acute medications. Refer to OMD EMR Core Data Set Standards (CDS-S) – Data Dictionary	M	U
PC07.07	The EMR Offering MUST display risk factors.	Refer to OMD EMR Core Data Set Standards (CDS-S) – Data Dictionary	M	U
PC07.08	The EMR Offering MUST display medical alerts and special needs.	Refer to OMD EMR Core Data Set Standards (CDS-S) – Data Dictionary	M	U
PC07.09	The EMR Offering SHOULD provide a method of re-ordering/sorting the CPP items at the EMR user's discretion.	The EMR user SHOULD be able to order the list in any way they choose for each CPP category for a patient: <ul style="list-style-type: none"> a) Ongoing Health Conditions b) Past Medical and Surgical History c) Family History d) Immunization Summary e) Allergies and Adverse Reactions f) Medication Summary g) Risk Factors h) Medical Alerts and Special Needs <p>Allowing the EMR user to only sort the items alphabetically will not satisfy the requirement.</p> <p>Re-ordered items should be maintained on the patient CPP in subsequent logins.</p>	O	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC07.10	The EMR Offering MUST provide the ability to record and update all the CPP categories.	<p>At a minimum, the following CPP categories MUST be managed from the encounter:</p> <ul style="list-style-type: none"> • Diagnosis • Procedures • Medication Summary <p>Medical records MAY be selected and managed from the encounter note to update the CPP.</p> <p>IMPORTANT: In the context of the current requirement "encounter" refers to SOAP Notes and Progress Notes.</p>	M	U
PC07.11	The EMR Offering MUST be able to customize the CPP Summary view to manage one or more sections of the CPP categories.	<p>At a minimum, the EMR user MUST be able to:</p> <ul style="list-style-type: none"> • Add and remove CPP categories for display. • Add and remove discrete data information to display within the CPP categories. <p>Customizations MAY be implemented at the EMR user level and/or EMR clinic level.</p> <p>Customizations MUST be maintained in subsequent logins by the EMR user.</p> <p>Requiring the EMR user to request support for customization is not an accepted solution.</p>	M	U
PC07.12	The EMR Offering SHOULD be able to support additional customizations of the CPP, beyond the ones specified in PC07.11.	<p>Accepted solutions include (but are not limited to):</p> <ul style="list-style-type: none"> • Resizing CPP categories to optimize data display and scrolling <p>Any customization SHOULD be maintained in subsequent logins by the EMR user.</p>	O	U
PC07.13	The EMR Offering MUST support the functionality to print the CPP Summary.	<p>The EMR Offering MUST have the functionality to:</p> <ul style="list-style-type: none"> • print the CPP Summary as a single operation • select CPP categories for inclusion/exclusion in the printout • remove medical records from a selected CPP category (optional) <p>Printed CPP Summary MUST include:</p> <ol style="list-style-type: none"> a) Clinic letterhead (Clinician name, Clinic name / address / phone number) b) Patient information (name, HCN, address, phone number) c) Print Date d) Page Number [x/y] <p>The EMR Offering MAY have the functionality to print the medical records within a CPP category:</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<ul style="list-style-type: none"> In the order displayed in the EMR Offering Descending chronological order (most recent displayed first) by onset date <p>IMPORTANT:</p> <p>In the context of current requirement, "onset date" refers to the date medical / non-medical condition (e.g. procedure, adverse reaction, etc.) occurred.</p>		

2.8 Encounter Documentation Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC08.01	The EMR Offering SHOULD provide forms or templates for common encounters that can be modified by an EMR user.	Examples: SOAP (Subjective, Objective Assessment Plan), Annual Physical, Ante-natal, etc.	O	U
PC08.02	The EMR Offering MUST automatically include an EMR user identifier in each part of the encounter note to support the shared creation of encounter documentation.	<p>The following would NOT meet the requirement:</p> <ul style="list-style-type: none"> Manual entry of clinician identification (clinician's name and designation) Comparing encounter note versions to identify what information was entered by a clinician. Requiring the EMR user to access audit logs to view entry information. <p>Allowing the EMR user to toggle identifying information within the encounter note view is acceptable if the identifier information can be retrieved.</p>	M	U
PC08.03	The EMR Offering MUST support free-form text notes that are tied to each "encounter note".	<p>The "free-form text notes" are notes that can be attached to a signed-off "encounter note" and it becomes part of the permanent patient record.</p> <p>The EMR Offering MUST track the timestamp, user and content for all changes to the "free-form text note".</p> <p>In the context of current requirement:</p> <ul style="list-style-type: none"> "Encounter note" refers to Progress Note and SOAP Note. "Clinician identifier" refers to clinician's name and designation. Date and time of sign-off MUST be captured. 	M	U

PC08.04	The EMR Offering MUST have the functionality to view and print all encounter documentation of a patient in chronological order.	<p><u>Based on Ontario Regulation 114/94, Section 2</u></p> <p>The EMR Offering MUST provide the capability to display and print all encounter types in chronological order, ascending or descending. This includes but is not limited to:</p> <ul style="list-style-type: none"> • Encounter Notes • Prescription History • Reports • Requisition Forms • Scanned Documents • Generated Letters • Referrals <p>IMPORTANT:</p> <p>All encounter documentation MUST incorporate associated clinical materials such as letters, documents and forms.</p> <p>In cases where the EMR Offering cannot print these materials in-line with the encounter notes, the EMR Offering MUST implement clear, unique identifiers to map the printed encounter to its attachments.</p>	M	U
PC08.05	The EMR Offering MUST have the functionality to display a patient's encounter history in chronological order, with the option to print the record within a selected date range.	At a minimum, the EMR user MUST be able to select both a start date (day, month, year) and an end date for the date range to satisfy this requirement.	M	U
PC08.06	The EMR Offering MUST provide the functionality to discretely capture/record multiple diagnosis from within an "encounter note".	<p>The EMR Offering MUST have the functionality to allow clinicians to:</p> <ul style="list-style-type: none"> • Save diagnosis in the "encounter note" • Save diagnosis in the "encounter note" and CPP (discretely) at the same time <p>The following implementations are not accepted:</p> <ul style="list-style-type: none"> • Requiring the EMR user to navigate to a different location within EMR to record the diagnosis. • Copy and paste the diagnosis from the "encounter note" to CPP (diagnosis category) and vice versa <p>In the context of current requirement:</p> <p>"Encounter note" refers to Progress Note and SOAP Note</p>	M	U
PC08.07	The EMR Offering MUST provide the ability to compile the components of a multi-part visit to create an encounter note that	Allow for a logical grouping of encounter documentation that indicates multiple activities within a single office visit.	M	U

	represents a single office visit per patient.			
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2.9 Schedule Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC09.01	The EMR Offering MUST maintain appointment data for a patient.	Refer to the EMR CDS-S Standard Specification for appointment data elements.	M	U
PC09.02	The EMR Offering MUST provide the ability to flag appointments as critical.	All appointments flagged as "critical" MUST be visually distinct in the appointment schedule.	M	U
PC09.03	The EMR Offering MUST integrate patient appointment with the billing component to avoid duplicate patient data entry.	The EMR Offering MUST transfer at least two elements from the scheduling that are required to complete the billing. a) The patient's HCN b) Service date c) Clinician Billing # (optional)	M	U
PC09.04	The EMR Offering MUST be able to open a patient's medical record directly from a scheduled appointment.	Requiring the EMR user to perform another search for the purpose of opening the patient chart is not an accepted solution.	M	U
PC09.05	The EMR Offering MUST support the ability to view the appointment schedule of two or more clinicians per screen.	The EMR Offering MUST ensure that appointment dates & times are synchronized on the screen when scrolling.	M	U
PC09.06	The EMR Offering MUST support searching for the next available appointment for a clinician.	The EMR Offering MUST perform the search by following parameters in a single function: a) Clinician b) Day of the week c) Time of day d) Appointment type The EMR Offering MAY support searching for the next available appointment for all clinicians in a clinic setting following same business rules as for a selected clinician. The functionality to perform the search MUST be from within the EMR and not a generated report.	M	U
PC09.07	The EMR Offering MUST support printing of the clinician schedule as a day-	The EMR Offering MUST support the functionality to print the day-sheet appointments for all clinicians OR for selected clinicians.	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
	sheet, ordered alphabetically by patient name.	<p>The printed list MUST contain additional information:</p> <ul style="list-style-type: none"> • Patient name • HCN (optional) • Appointment reason (optional) • Patient contact information (phone number) (optional) 		
PC09.08	The EMR Offering MUST support the printing of the clinician schedule as a day-sheet, ordered chronologically.	<p>The EMR Offering MUST support the functionality to print the day-sheet appointments for all clinicians OR for selected clinicians.</p> <p>The printed list MUST contain additional information:</p> <ul style="list-style-type: none"> • Patient name • HCN (optional) • Appointment reason (optional) • Patient contact information (phone number) (optional) <p>The printed day-sheet should be in ascending order (i.e., the earliest time should appear at the top of the day-sheet).</p>	M	U
PC09.09	The EMR Offering SHOULD support printing of the clinician schedule as a day-sheet, ordered by chart number.	<p>The EMR Offering MUST support the functionality to print the day-sheet appointments for all clinicians OR selected clinicians</p> <p>The printed list MUST contain additional information:</p> <ul style="list-style-type: none"> • Patient name • Patient chart # • HCN (optional) • Appointment reason (optional) • Patient contact information (phone number) (optional) <p>The printed day-sheet SHOULD be in ascending order (i.e., the earliest time should appear at the top of the day-sheet).</p>	O	U
PC09.10	The EMR Offering SHOULD support pre-configuration of schedule slots or blocks by the clinician.	The EMR Offering MAY use color codes to visually differentiate between scheduled slots or blocks.	O	U
PC09.11	The EMR Offering SHOULD support planned periods of multiple appointments to a single start time for a clinician.	<p>Ad hoc double booking does not meet the requirement.</p> <p>Appointments MUST be:</p> <ul style="list-style-type: none"> • Visually distinct. • Preplanned and configured. 	O	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<ul style="list-style-type: none"> Able to search for the next available slot or overbooking occurs only after the planned period is full. 		
PC09.12	The EMR Offering MUST support the functionality to allow the EMR user to ad-hoc double book an appointment slot.	<p>The EMR Offering MUST ensure that ad-hoc double bookings are:</p> <ul style="list-style-type: none"> Visually distinct in the Appointment Schedule; and Included in the printed day-sheets. <p>The ability to double-book an appointment (i.e. two or more appointments use the same time slot (overlap)) MUST be implemented without the need to configure the appointment schedule for the clinician.</p>	M	U
PC09.13	The EMR Offering MUST support viewing the appointment schedule both with and without personal patient data being displayed.	<p>The EMR user MUST be able to toggle between displaying and hiding patient data viewable in the appointment schedule. The toggling is between:</p> <ul style="list-style-type: none"> Displaying only patient name. Displaying patient name / HCN / DOB / gender. <p>The EMR Offering MAY have the functionality to display patient personal data when hovering over the patient appointment in the Appointment Schedule.</p>	M	U
PC09.14	The EMR Offering SHOULD support drag and drop rescheduling.	Can be cut and pasted, or any other means of rescheduling without a delete and add process.	O	U
PC09.15	The EMR Offering MUST maintain the patient's status in the clinic.	The EMR Offering MAY have pre-defined status definitions or allow for EMR user-defined status.	M	U
PC09.16	The EMR Offering MUST provide the ability for a clinician to view and modify their schedule.		M	U
PC09.17	The EMR Offering MUST provide EMR users with the ability to view the appointment history for any given patient.	<p>The "appointment history list" MUST contain both past and future appointments.</p> <p>The EMR Offering MAY:</p> <ul style="list-style-type: none"> Display appointments in reverse chronological order (most recent appointment displayed first). Support the functionality to print the list. 	M	U

2.10 Referral Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC10.01	The EMR Offering MUST support the functionality to generate Referral Letters(s).	<p>The Referral Letter MUST include:</p> <ul style="list-style-type: none"> a) Patient demographics (i.e., name, age, DOB, gender, HCN, patient alternative contact) b) Referring clinician's letterhead (clinician name and clinic information) c) Referred clinician information (name and contact information) (if available) d) Patient clinical data selected by the clinician: <ul style="list-style-type: none"> i. CPP categories ii. Lab test reports / test results iii. Encounter notes (Progress Notes / SOAP Notes) (optional) iv. Consultation notes received from specialists v. Reports received from external sources/ entities (e.g., diagnostic images) e) Able to be edited to provide letter-specific content (free-text notes) f) Referral Letter Date (automatically generated by the EMR Offering) <p>The EMR Offering MUST:</p> <ul style="list-style-type: none"> a) Save and preserve the original Referral Letter (updates to the patient medical data MUST NOT affect the original Referral Letter) b) Print Referral Letter, including: <ul style="list-style-type: none"> • all contents listed above • page number (x/y) and the print date (optional) 	M	U
PC10.02	The EMR Offering MUST track patient's Referral Letters over time (Referral Letter list).	<p>At a minimum, the Referral Letter list MUST include:</p> <ul style="list-style-type: none"> • Referral Letter Date • Referring Clinician • Referred Clinician • Referral Letter Status (e.g. in-progress, outstanding, complete, etc.) • Referral Specialty (optional) • Referral Letter Notes • Access to selected Referral Letter <p>Any of the following solutions are accepted:</p> <ul style="list-style-type: none"> a) Access patient's Referral Letters list from the patient chart. b) Access patient's Referral Letters list from a centralized location in the EMR Offering. <p>The EMR Offering MUST provide reminders for outstanding Referral Letters.</p>	M	U

		<p>The Referral Letter outstanding reminders MUST:</p> <ul style="list-style-type: none"> • Be in the patient chart • Be visually distinct • Identify the Referring Clinician • Identify the Referred Clinician • Be turned off at the EMR user discretion <p>IMPORTANT:</p> <p>The algorithm (logic) used to flag outstanding Referral Letters can be implemented at the EMR Vendor discretion. Manually flagging a Referral Letter as outstanding is not an accepted solution.</p>		
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2.11 Reporting, Query and Communications

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC11.01	The EMR Offering MUST provide the ability to produce all EMR data in a hard copy format.	<p>For this requirement to be met, this MUST be EMR user-administered and does not require an EMR vendor to attend the process.</p> <p>MUST be able to print information for a single patient record.</p> <p>See “CPSO Policies - Medical Records” in the Related Documents section.</p>	M	U
PC11.02	<p>The EMR Offering MUST have the functionality to allow EMR users to set up preventive care parameters required for Recall List Report and Cumulative Bonus Report generation for each of the five (5) preventive care categories:</p> <ul style="list-style-type: none"> • Mammogram Screening • HPV Screening (old pap) • Colorectal Screening • Childhood Immunization • Influenza Immunization 	<p>The EMR users MUST be able to set up and maintain the following parameters for the target population at the clinic level:</p> <ol style="list-style-type: none"> Enrolment status Age Gender Procedure/vaccination timeline Exclusion codes or a means to exclude the patient from a set effective date <p>The parameters applicable to the target population MUST be adjustable and saved:</p> <ul style="list-style-type: none"> • On a fiscal year basis for Cumulative Bonus Reports • On a real-time basis for Recall List Report <p>Hard coding the parameters would not satisfy this requirement.</p> <p>Service Enhancement Codes are set by MOH for applicable Physician Group Agreements. Please refer to the OHIP Bulletins and MOH guidelines in the “Related Documents” section.</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC11.03	The EMR Offering MUST generate the Recall List report for preventive care activities/programs for patients enrolled to a physician.	<p>Recall List Report MUST include/indicate:</p> <ul style="list-style-type: none"> a) Target population b) The physician to whom the patient is enrolled c) Patient information (name, HCN, age, gender, phone number, address) d) Guardian information (name, phone number, and address) for Childhood Immunizations e) Last procedure date f) Patient eligibility status for engagement (patient eligible to receive procedure for current fiscal year and needs to be engaged via letter, phone call or other meaning of engagement) Whether the patient is entitled to receive the first letter, second letter or phone call <ul style="list-style-type: none"> • real-time (automatically) calculated based on setup parameters for the target population and procedure date g) Last engagement date <ul style="list-style-type: none"> • manually recorded by the EMR user for phone calls / automatically generated by the EMR when printing letters • the value must be reset to "null" for each "preventive care cycle" h) Notes <p>The Recall List Report is a real-time report. Updates to patient meta data, report parameters for the target population, medical records (e.g. procedure date) MUST be automatically reflected in the recall list report for the physician.</p> <p>Requiring the EMR user to re-enter any information (e.g., patient metadata, procedure) which is already in the EMR Offering would not satisfy the requirement.</p> <p>The EMR Offering MUST have the functionality to generate the Recall List Report for:</p> <ul style="list-style-type: none"> • Patient rostered to selected physician (if patient is not enrolled) <p>IMPORTANT:</p> <p>Service Enhancement Codes are set by the MOH for applicable Physician Group Agreements. See the OHIP Bulletins and MOH guidelines.</p> <p>In the context of the current requirement, "preventive care cycle" is determined by the frequency a preventive care procedure is required to be performed as indicated/stated in the OHIP Bulletins and MOH guidelines.</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC11.04	The EMR Offering MUST have the functionality to generate patient letters directly from the Recall List Report.	<p>At a minimum, the EMR Offering MUST be able to:</p> <ul style="list-style-type: none"> a) Generate the letters in a batch or individually (both MUST be supported). b) Generate letters without requiring the EMR user to do another patient lookup or manually entering information. c) Automatically generate last engagement date (date the letter is printed). <p>Letters MUST meet requirements listed in the MOH Service Enhancement Codes Primary Care Agreements:</p> <ul style="list-style-type: none"> • Indicate the procedure type, benefits and the date of the last procedure. • The name and address of the patient or guardian (for Childhood Immunizations). • Clinician letterhead (clinician name, clinic address and phone number). 	M	U
PC11.05	The EMR Offering MUST have the functionality to generate Cumulative Bonus reports for preventive care activities/programs for patients enrolled to a physician as per configured fiscal years.	<p>Cumulative Bonus report MUST include/indicate:</p> <ul style="list-style-type: none"> a) The target population. b) The physician to whom the patient is enrolled. c) Patient information (name, ON-HCN, age, gender). d) Last procedure date. e) Whether the eligible patients from the target population have received the procedure or not. f) Percentage of eligible patients from the target population who have received the procedure. <p>The Cumulative Bonus Report is a real-time report. Updates to patient metadata, parameters applicable to the target population and medical record (e.g., procedure date) MUST be automatically reflected in the Cumulative Bonus report.</p> <p>The EMR Offering MUST support the functionality to allow the EMR user to generate Cumulative Bonus Reports for multiple fiscal years (including current fiscal year).</p> <p>IMPORTANT:</p> <p>Service Enhancement Codes are set by the MOH for applicable Physician Group Agreements. See the OHIP Bulletins and MOH guidelines.</p>	M	U
PC11.06	The EMR Offering MUST provide a report writer that allows the EMR user to develop ad-hoc queries and generate reports.	The EMR user MUST be able to create the query and generate the report without requiring an EMR vendor to attend the process.	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<p>Any discrete data field specification requirements satisfied by the EMR Offering can be selected for report parameters.</p> <p>At a minimum, the report writer MUST support:</p> <ul style="list-style-type: none"> • The selection of reported fields • Boolean filtering capabilities based on “AND”, “OR”, and “NOT” logic. 		
PC11.07	The EMR Offering MUST assist clinicians with consistent data entry to facilitate effective data discipline.	<p>Any of the following are accepted solutions:</p> <ul style="list-style-type: none"> a) Coding schemas b) Drop-down lists c) Calendars (for recording date) <p>The EMR Offering MAY support "spell checker".</p>	M	U
PC11.08	The EMR Offering MUST be able to search for and report on ALL text fields in the EMR Offering.	<p>Text fields include any free-form text or notes fields.</p> <p>Able to search within the text fields for partial matches.</p>	M	U
PC11.09	The EMR Offering MUST be able to search for and report on ALL data fields in the EMR Offering.	Image data is not required.	M	U
PC11.10	The EMR Offering MUST be able to search for and report on ALL data and text fields in the EMR Offering concurrently (i.e., in a single report)	<p>Able to search within text fields for partial matches</p> <p>Image data is not required.</p>	M	U
PC11.11	The EMR Offering SHOULD provide report templates for EMR data that may be modified by the EMR user.		O	U
PC11.12	The EMR Offering MUST allow the creation of static cohorts of patients for tracking purposes.	<p>To satisfy this requirement, the EMR user MUST be able to define the name and population of their cohort(s).</p> <p>The EMR user MUST be able to add a population of patients individually or in bulk to the cohort.</p> <p>Each patient in the EMR Offering can belong to more than one cohort.</p>	M	U
PC11.13	The EMR Offering MUST provide functionality to generate an EMR Usage Metrics Report.	<p>Report indicates:</p> <ul style="list-style-type: none"> a) Clinician for whom the report is being generated b) Date range of report c) Practice profile information 	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		d) Metrics for the patients rostered to clinician <ul style="list-style-type: none"> i. Scheduled appointments ii. Billing (OHIP, WSIB, private, uninsured) iii. Encounter notes created iv. Problems entered in the Ongoing Health Condition list v. Stored documents (including scanned documents or external documents received from an interface) vi. New and renewed prescriptions vii. Lab test results received electronically viii. Alerts/reminders generated Refer to the “EMR Usage Metric Report – Sample” section of this document.		

2.12 Workflow Management

To meet the requirements of this section, an EMR Offering **MUST** have one or more work queues.

A work queue (also known as an in-basket, in-box, or task list) supports the management of tasks.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC12.01	The EMR Offering MUST support linking work queue items to a patient record.	EMR Offering MUST provide the ability to open the patient record in a single action.	M	U
PC12.02	The EMR Offering MUST support the classification of task priority.	Priority can be indicated by urgent, low, etc., or a priority checkbox.	M	U
PC12.03	The EMR Offering MUST supports free-form text notes that are tied to each task.		M	U
PC12.04	The EMR Offering SHOULD provide the ability to associate a task with a laboratory test report/result.	Laboratory test report/result can be opened from the task. Assignment of the EMR user’s access to lab information MUST comply with appropriate security permissions for that EMR user.	O	U
PC12.05	The EMR Offering SHOULD provide the ability to associate a task with an external document.	Document records can be opened from the task. An assigned EMR user’s access to documents MUST follow appropriate security permissions for that EMR user.	O	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC12.06	The EMR Offering MUST support the creation of new ad hoc tasks and their assignment to other specified EMR users.		M	U
PC12.07	The EMR Offering MUST support the creation of new ad hoc tasks and their assignment to others by role.		M	U
PC12.08	The EMR Offering MUST support the creating, actioning and accessing of tasks anywhere in the application.		M	U
PC12.09	The EMR Offering MUST store selected work queue tasks and status as a part of a patient's medical record.	Storing this information only in the audit log is not acceptable.	M	U
PC12.10	The EMR Offering SHOULD customize work queue screens for different roles.	Work queues can be customized by roles such as nursing, physicians, receptionists, etc.	O	U
PC12.11	The EMR Offering MUST support automated generation of tasks and patient follow-up tasks to a work queue.	<p>At a minimum, the following tasks MUST be automatically generated:</p> <ul style="list-style-type: none"> a) Outstanding lab requests, and other tests (e.g., Diagnostic Imaging) b) Appointment reminders <p>This requirement does not include preventive care (e.g., preventive care reminders).</p> <p>The requirement is not met if an EMR user accesses the patient chart only to view the task.</p> <p>The EMR Offering allows the ability to turn off this functionality for each type of task.</p>	M	U
PC12.12	The EMR Offering MUST automatically create a task for past-due targeted health maintenance activities and assigns it to a pre-defined work queue; the tasks MUST be generated by the EMR Offering, not created by an EMR user.	<p>Running a query to generate tasks on all applicable records is acceptable.</p> <p>The EMR user MUST be able to assign/redirect tasks to a particular EMR user or role.</p> <p>The EMR user MUST be able to turn off this functionality.</p> <p>See the OHIP Bulletins and MOH guidelines.</p>	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC12.13	The EMR Offering MUST make all the unsigned patient information visible in the patient chart and clearly indicate its unsigned status.	This applies to all patient information (e.g., reports) and for all encounters that require sign-off such as: <ul style="list-style-type: none"> a) Reports received through an interface. b) Reports scanned into the EMR Offering. c) Reports manually keyed. 	M	U
PC12.14	The EMR Offering MUST support a clinician's "sign-off" function to indicate data that becomes part of the permanent patient medical record.	At a minimum, sign-off MUST be available for: <ul style="list-style-type: none"> a) Encounter Documentation b) Reports that are: <ul style="list-style-type: none"> i. Received through an interface ii. Scanned into the EMR Offering iii. Manually keyed into the EMR Offering Sign-off information (including sign-off date and identity of the clinician) MUST be: <ul style="list-style-type: none"> • Visible in the patient's chart. • Captured in the audit log. 	M	U
PC12.15	The EMR Offering MUST support a "sign-off" function for approval of trainee actions.	The trainee is not necessarily a physician – may be a nursing student, etc.	M	U
PC12.16	The EMR Offering MUST support multiple clinician "sign-offs" on patient information and indicates the sign-off date and clinician identity.	This applies to any patient information that requires clinician sign-off such as: <ul style="list-style-type: none"> a) Encounter documentation b) Reports that are: <ul style="list-style-type: none"> i. Received through an interface ii. Scanned into the EMR Offering iii. Manually keyed into the EMR Offering Only a single copy of the report is posted to the patient's chart. Sign-off information (including sign-off date, clinician's name and designation) MUST be: <ul style="list-style-type: none"> • Visible in the patient's chart. • Captured in the audit log. 	M	U
PC12.17	The EMR Offering MUST provide the functionality from the "inbox" to allow the EMR user to re-display an item that has been signed-off.	This applies to all patient information signed off, such as: <ul style="list-style-type: none"> a) Reports received through an interface. b) Reports scanned into the EMR Offering. c) Reports manually keyed. Additionally, the EMR Offering MUST provide the ability to search and review items that were signed off on a particular date or date range per EMR user.	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		This is not an undo function, but rather the ability to display (return to) previously viewed patient information without requiring the EMR user to recall patient demographic details.		

2.13 Billing Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC13.01	The EMR Offering MUST support the processing of concurrent Ontario billing models of fee-for-service, shadow partial payment billings, and Physician Group bonus codes.	See the OHIP Bulletins and MOH guidelines.	M	U
PC13.02	The EMR Offering MUST provide basic error checking and alert the user of any errors.	<p>At a minimum, the basic error checking MUST be provided when registering patients:</p> <ul style="list-style-type: none"> a) Ontario HCN - check digit b) HCN duplicate <p>Edits for all mandatory billing fields:</p> <ul style="list-style-type: none"> • Service date • Clinician number • HCN • Name • Date of Birth (DOB) • Gender • Fee code and fee claimed • Checks all dates are valid dates and, in the past. 	M	U
PC13.03	The EMR Offering MUST provide automated reconciliation, claim re-submission and print reconciliation reports.	<p>The reconciliation reports can be either the entire Machine-Readable Output (MRO) data file or include the MOH-defined data fields, based on their MRO record type.</p> <p>The EMR Offering MUST support the resubmission of rejected claims without the need to re-enter data.</p> <p>See the OHIP Bulletins and MOH guidelines.</p>	M	U
PC13.04	The EMR Offering MUST support reading the health card through a card reader device and looking up the patient in the EMR application database.	<p>The EMR Offering MUST:</p> <ul style="list-style-type: none"> a) Notify of version code discrepancies, and b) Upon EMR user request, automatically update the patient record with the following demographic data associated with the HCN 	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		<ul style="list-style-type: none"> Name Gender DOB 		
PC13.05	The EMR Offering MUST support WSIB billing through MRI (Machine Readable Input) files.		M	U
PC13.06	The EMR Offering SHOULD support the creation of a claim directly from the patient encounter information.	<p>The EMR Offering SHOULD transfer all pertinent billing data that is present in the clinical record.</p> <p>Pertinent data includes, but is not limited to:</p> <ul style="list-style-type: none"> Patient information Clinician information Service date Procedure code Diagnosis code Location Clinic/hospital number 	O	U
PC13.07	The EMR Offering SHOULD be able to transfer and translate diagnostic codes for billing purposes from the EMR component.	Diagnosis code information comes from the patient's EMR data and is not manually entered by the EMR user.	O	U
PC13.08	The EMR Offering MUST support the manual entry of non-OHIP billing transactions.	<p>Non-OHIP billing transactions include, but are not limited to:</p> <ul style="list-style-type: none"> Direct to patient Reciprocal 3rd party 	M	U
PC13.09	The EMR Offering MUST provide aged receivables listings for all billing types (not solely limited OHIP).	<p>The list MUST indicate:</p> <ol style="list-style-type: none"> Patient ID Service provided Service date Outstanding amount <p>Any ageing buckets are acceptable.</p> <p>Can be any report to manage outstanding claims.</p>	M	U
PC13.10	The EMR Offering MUST contain the current OHIP fee schedule including preventive care codes.		M	U
PC13.11	The EMR Offering MUST maintain and use a historical OHIP fee schedule for the prior year.	Prior fee schedule information may be required for resubmission purposes.	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC13.12	The EMR Offering MUST provide lookup of services and diagnoses by both their codes and descriptions.		M	U
PC13.13	The EMR Offering MUST force reconcilable disposition of all scheduled appointments (i.e., provides a screen or report that lists patient appointments that have no billings).	The EMR user MUST take some action to remove unbilled appointments from the list. Deleting appointments does not meet the requirement.	M	U
PC13.14	The EMR Offering MUST support direct third-party billings with invoices.	Able to be generated on demand. At a minimum, the third-party billings with invoices MUST include: a) Clinician name b) Patient name or ID c) Payor address d) Service date e) Service f) Itemized amount(s) g) Total amount billed	M	U
PC13.15	The EMR Offering MUST support direct third-party billings with statements.	Able to be generated on demand. At a minimum, the third-party billings with statements MUST include: a) Clinician name b) Patient name or ID c) Payor address d) Service date e) Service f) Itemized amount(s) amount paid g) Balance Receipts are not sufficient.	M	U
PC13.16	The EMR Offering MUST support billing lookup.	MUST support billing lookup by each of the following: a) Patient HCN b) Patient name c) OHIP claim # or Provincial claim# or Accounting # The Provincial claim # is the claim number assigned by the corresponding Provincial claim payment system.	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		Accounting # is assigned by EMR Offering or EMR user to a claim.		
PC13.17	The EMR Offering MUST enable updating of billing codes through the OHIP fee schedule master update file, as provided by MOH in the specified format.	Refer to the "OHIP Fee Schedule Master" in the Related Documents section.	M	U
PC13.18	The EMR Offering SHOULD notify the EMR user of changes to billing codes per the updates in the fee schedule master.	At a minimum, notifications SHOULD be provided for: <ul style="list-style-type: none"> a) Updated Fees b) Updated Effective Date c) Updated Expiration Date d) New billing codes 	O	U
PC13.19	The EMR Offering MUST provide access to OMA-suggested fees for uninsured services and third-party services, including HST eligibility.	OMA services and third-party suggested fees for uninsured services can be accessed from scheduling and billing modules, and the patient's medical record. Refer to "Physician's Guide to Third-Party and Other Uninsured Services" published by the OMA for a list of suggested fees for uninsured services and third-party services.	M	U
PC13.20	The EMR Offering MUST provide the capability of correcting a billing entry error without classifying it as a write-off.	A 'write-off' implies an uncollectable amount. These amounts should be coded and treated as such. An 'error' is an honest error and should be treated as such. Write-offs and errors should be associated with a reason code/reason description. Report(s) that show write-offs and error corrections MUST show each.	M	U

2.14 Data Management

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC14.01	The EMR Offering MUST retain medical records information.	It is recommended to maintain records for a minimum of 15 years. Refer to the "CPSO Policies - Medical Records" in the Related Documents section.	M	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC14.02	The EMR Offering MUST retain billing transaction details for at least seven years.	This standard may be updated by MOH.	M	U
PC14.03	The EMR Offering MUST support a minimum of 20,000 patient records for up to 10 years of data without the need to upgrade the system.	The EMR Offering MUST support the minimum number of patients without necessitating upgrades to the Database Management System (DBMS), Operating System (OS), or related software components. This requirement applies to both hosted and local EMRs.	M	U
PC14.04	The EMR Offering MUST provide a complete system (applications and data) backup and recovery process.	Based on Ontario Regulation 114/94, Section 20 (7). Back-up can be full or incremental, etc. Recovery can be to the last backup, point of failure, etc.	M	U
PC14.05	The EMR Offering SHOULD store the external documentation using a database solution.	Refer to the external documentation described in section 2.6 External Document Management A solution that stores documents in the file system (server or client) only does not satisfy the requirement.	O	U
PC14.06	The EMR Offering SHOULD encrypt patient data and clinical management data resident on server(s) with a strength of at least 128-bits.	A solution that only encrypts data as it is transmitted over the network does not satisfy the requirement.	O	U
PC14.07	The EMR Offering MUST harden the EMR server in preparation for server-level encryption.	Server hardening consists of creating a baseline for the security of the application server. Threats to Personal Health Information breaches via external access are greatly reduced by eliminating entry points and minimizing system software. Physical security is elevated when all application data and information is encrypted. This guideline does not apply to Hosted EMR Offerings. Refer to the "Server Hardening Checklist" in the Related Documents section.	M	U
PC14.08	The EMR Offering MUST co-exist with an anti-malware solution on the same server without conflicts.	The EMR vendor MUST recommend to clients an anti-malware solution that does not negatively impact the EMR Offering. The recommended solution MUST coexist with the EMR Offering on the same server without creating any conflicts.	M	U

2.15 Implementation Support

This section consists of the implementation support requirements. EMR implementation support means that a representative of the vendor is available to assist customers with training and any questions about or issues encountered with the vendor's EMR Offering within the defined availability.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC15.01	The EMR vendor MUST provide regular EMR Offering support from 8 AM – 8 PM Monday through Thursday, 8 AM – 5 PM Friday, and 9 AM – 2 PM Saturday (as per the applicable provincial time zone)		M	U
PC15.02	The EMR vendor SHOULD provide an additional EMR Offering support (e.g., 7 x 24 support.)		O	U
PC15.03	The EMR vendor MUST be able to troubleshoot common technical/user issues via electronic/remote support.	<p>To satisfy this requirement, the EMR vendor MUST be able to provide support by viewing the EMR user interface without physically being at a site, provided appropriate consent has been given to the EMR vendor to do so.</p> <p>Considerations MUST be made for the privacy and security of Personal Health Information.</p>	M	U
PC15.04	The EMR vendor MUST be able to provide simple upgrades and code corrections remotely.	ent, the EMR vendor MUST be able to: nistrator to download, accept and execute he user and make updates remotely.	M	U
PC15.05	The EMR vendor MUST make the EMR user documentation available in electronic format.	<p>The documentation MUST be comprehensive of all available EMR functionality.</p> <p>To satisfy this requirement, documentation MUST either be distributed to or made available for download by customers.</p> <p>The document MUST be searchable.</p>	M	U
PC15.06	The EMR Offering SHOULD provide context-sensitive help within the application.	<p>Help SHOULD be invoked from within the EMR user interface and specific to the screen, function, or function groups being used.</p> <p>The use of tooltips to provide a brief description of a function does not satisfy this requirement.</p>	O	U

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		Opening up the entire training document and searching does not satisfy this requirement.		
PC15.07	The EMR vendor MUST offer EMR training.	At a minimum, training MUST be offered on all functionalities described in this specification.	M	U

2.16 Interface Requirements

The vendor will be required to interface their EMR Offering to other related systems.

Technical details of interfaces (such as message structure, frequency of update, push or pull) are available from interface owners.

The following table summarizes the vendor requirements for interfaces.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC16.01	The EMR Offering MUST support the functionality to interface with MCEDT (Medical Claims Electronic Data Transfer) for billing purpose.	Refer to the “Technical Specifications – Interface to Health Care Systems” in the Related Documents section.	M	U
PC16.02	The EMR vendor MUST support integration with Ontario commercial laboratories.	<p>The EMR vendor MUST support integration with at least one of the following laboratories:</p> <ul style="list-style-type: none"> • Dynacare • LifeLabs <p>For this requirement to be met, the EMR vendor MUST provide a certification letter confirming that the EMR Offering has successfully completed conformance with the Ontario laboratory.</p> <p>The letter MUST be dated within the previous twelve (12) months.</p>	M	U
PC16.03	The EMR Offering MUST have the functionality to support the validation of Ontario health card number (HCN).	<p>The EMR Offering MUST support at least one of the following methods to validate the Ontario HCN:</p> <ul style="list-style-type: none"> • OBEC (Overnight Batch Eligibility Checking) • HCV (Real-Time Health Card Validation) <p>Refer to the Health Card Validation Reference Manual in the Related Documents section.</p>	M	U

2.16.1 Claims and Incentive Payments

The MOH Claims system processes claims, creates payments and provides error reports and remittance advice back to clinicians. Vendors are required to implement the current interface specification and to remain current with this specification and any changes thereto.

Detailed specifications for both submitting claims and receiving error reports and remittance advice, as well as contact information for testing the interface, can be found in the “Technical Specifications – Interface to Health Care Systems” referenced in the Related Documents section.

2.16.2 Commercial Laboratories

An EMR Offering’s ability to receive laboratory results from major commercial labs is subject to the following pre-conditions:

- The laboratory has made its interface specification publicly available; and
- The potential electronic transactions for the laboratory represent at least 5% of the overall Ontario volume of electronic laboratory transactions.

The specifications for electronic interfaces for two commercial laboratories meeting the above conditions can be obtained directly from the laboratories themselves.

- Dynacare – www.dynacare.ca
- LifeLabs – www.lifelabs.com

2.16.3 Health Card Validation

The MOH Health Card Validation (HCV) system allows healthcare providers to validate the eligibility of the cardholder and the status of his or her health card and version code.

The HCV Reference Manual, containing detailed specifications for current HCV access options, as well as contact information for testing the interface, can be found in the “Health Card Validation Reference Manual” in the Related Documents section.

2.17 Licensing Requirements

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

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
PC17.01	The EMR vendor MUST have a quality management system (QMS) that includes patient safety within its definition of quality.	<p>The EMR vendor MUST provide either:</p> <ul style="list-style-type: none"> a) A current ISO 13485 certificate, or b) A current ISO 9001 certificate + provide an excerpt of the audited quality documentation (e.g., quality manual) that demonstrates the concept of patient safety (i.e., patients' freedom from unacceptable risk) was included in the description of: <ul style="list-style-type: none"> i. The needs and expectations of interested parties (ISO 9001:2015 Requirement 4.2) and ii. The scope of the quality management system (ISO 9001:2015 Requirement 4.3). 	M	U
PC17.02	The EMR vendor MUST have an active support contract for any third-party application or component used by, or as part of the EMR Offering.	<p>The EMR vendor MUST not continue the use of any third-party application that is beyond its end-of-life support contract.</p> <p>A mitigation plan MUST be submitted to OMD upon request for any third-party application that is beyond its end-of-life support contract, and be included in a Risk Assessment, as part of Privacy and Security requirements (Refer to P&S Spec.).</p> <p>Any software that has reached end-of-life MUST cease to be used after 30 days of knowing that it is end-of-life.</p>	M	N

3. APPENDIX A: SUPPORTING INFORMATION

3.1 EMR Usage Metrics Report (Req # PC11.13) - Sample

The vendor can produce reports related to EMR use metrics (sample below).

EMR Usage Report

Provider: Dr. J. Doe

Date Range: 01/01/10 – 01/03/10

Practice Profile

Practice Size: _____

Age and Gender Distribution:

Age Group - Years	Percentage	Male	Female
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0 - 19	30%	65%	45%
20 - 44	20%	20%	80%
45 - 64	30%	45%	55%
65 - 84	25%	40%	60%
85+	5 %	25%	75%

The number of unique patient visits (kept) demonstrates the use of the following EMR functionality in the identified time frame:

Scheduled Appointments	Billing ¹	Encounter Note ²	Ongoing Health Conditions ³	Stored documents ⁴	Prescriptions new/renewals	Use of reminders / alerts ⁵	Labs ⁶
100	98	100	75	50	46	100	25

Note:

1. Bill for services – includes OHIP, WSIB, other provincial plans, private insurance and uninsured (self-pay, third parties) invoicing
2. Encounter notes (SOAP, Progress Notes, etc.) for patients seen; progress note entry associated with a kept patient office visit
3. Ongoing health conditions, problems, and diagnoses from CPP
4. Store documents not originating from the practice; including any scanned documents or external documents delivered through an electronic interface (e.g., through Health Report Manager)
5. Generate automated alerts/reminders to support care delivery– includes medication alerts (drug-drug, drug-allergy, drug-condition); preventive care and chronic disease management reminders
6. Received lab results electronically, directly into the EMR from private labs or hospital labs

4. APPENDIX B: ADDITIONAL REFERENCES

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

DOCUMENT NAME	VERSION	PUBLICATION DATE
<p>Information and Procedures for Claiming the Cumulative Preventive Care Bonus (Ministry of Health, 2024)</p> <p>https://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/11000/bul11235_Info.pdf</p> <p><i>Note: Refer to the MOH bulletins for the most current information available</i></p>	N/A	2024-05
<p>Ontario's Routine Immunization Schedule (Ministry of Health, 2025)</p> <p>https://www.ontario.ca/page/ontarios-routine-immunization-schedule</p>	N/A	2025-09