This information sheet lists the standard default configuration settings that need to be set so that you can be assured that the product installed in your office is meeting all core requirements, including what elements must remain non-modifiable; what elements are user-modifiable during initial implementation and in the future; and what elements are recommended. Establishing these settings will ensure that at the outset, you, your clinic staff and your patients can all realize the maximum benefit from these very capable Electronic Medical Record (EMR) systems.

Introduction

The EMR functional requirements were arrived at after much clinical input and discussion to ensure a degree of standardization across EMR applications. In effect, they set high standards for EMR applications to advance patient care and safety while protecting providers and respecting their workflows.

The EMR applications are configurable to varying degrees and each EMR differs in the attributes that can be configured, which could result in dramatically different care delivered to patients in different clinics.

Practices that do not implement a minimum standard configuration may never realize the ultimate capability of the EMR that they are using, and they and their patients may never realize the optimal degree of care that can be delivered.

Configuration Settings

All EMR configuration settings that are needed to meet core functional requirements must be set as defaults by your EMR vendor, so that you can be assured that the product installed in your office is enabling you, your clinic staff and your patients to realize the maximum benefit from these very capable EMR systems.

In recognition of the fact that all physicians may not want every configuration set in the same manner, an effort has been made to assess what aspects of configuration must not be changed and what aspects can be reset after your Service Provider consults with you during initial implementation.

The PITO-Qualified EMRs offer robust decision support functionality. The default settings were established to ensure you are aware of these advantages and to help promote an active decision support paradigm. Because of this, you and your clinic staff may see a large number of reminders, recall notices and guidelines during the first few months' use of your EMR. As you respond to the decision support prompts, the list of suggested activities and care plan actions for your clientele can be expected to decrease.

Note: The included stipulations *only apply in those systems where the setting is configurable.* In the case of the date default, if a system does not have the ability to configure its date, this would not be mandatory. If an EMR can configure its date so that the month is a three alpha field, then it would be mandatory. *If a Service Provider's product does not already have the configuration capabilities to set the defaults included here, that Service Provider will not be expected to set them.* In addition, these settings only pertain to *implementations where a configuration exercise is still outstanding* (i.e. no retroactive application of these defaults is expected). For more information about the configuration of your EMR, please contact your EMR vendor.

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Functional Requirements - General		
Default (Non-modifiable)	**Default (Modifiable)**	**Recommendation**
Date Formats In all date formats, default the month as a three alpha field (e.g., Jan) rather than a numerical field. In all date formats, set the year to four digits.	Display INR with anticoagulant dosages.	
Mandatory fields Must not have a default value (must be blank).	Set phone area code prefix to mandatory.	

Functional Requirements - Clinical		
Default (Non-modifiable)	**Default (Modifiable)**	**Recommendation**
Corrected Lab Results Display manually changed results in the same priority as abnormal results.	**Lab units** Set manual lab entry fields to SI units.	**Lab Results Copy** Copy to the patient's family physician.
DI/Lab review DI and lab test tasks must be reviewed before deletion (or before the tests are signed off in the chart record).	**DI/Lab sign off** Sign off of DI and lab test results in the inbox must be reflected in the results stored in the patient's chart.	**DI display** Sort DI data chronologically with the most recent first.
Allergy Indicators Display manually entered allergy and adverse reaction indicators prominently on all clinical screens.	**Labels** On container and form labels, include physician name, MSP number, specimen site, date of service, time, patient name, DOB, PHN.	**Task Management** Sort and display tasks by priority.
Intolerance link Captured intolerance entries must always link to the primary allergy feature (even if entered elsewhere, e.g., immunization function, medication discontinuation screen, etc.)	**Patient Lab Instructions** Display instructions on lab requisitions.	**Patient Summary** Display all components in chronological order.
Allergy link Captured allergy entries must always link to the primary allergy feature (even if entered elsewhere, e.g., immunization function, medication discontinuation screen, etc.)	**Referral Letter pre-population** Include the following fields in the referral letter: demographics, reason for consultation, medications, allergies, problem list, medical and surgical history, visit notes and urgency.	**Capitalization of Free Form Text** Capitalize first letter of free form text in a paragraph; turn on spell check.

Functional Requirements - Clinical		
Default (Non-modifiable)	**Default (Modifiable)**	**Recommendation**
Graphs Graphs provided with the product must be clinically correct and relevant. For example: • diastolic/systolic readings need to be on same set of axes; • header information must contain the patient demographics and provider information; • a title, axis titles and axis units must be included; • lab test results must be reconciled to use the same base unit in order to display comparable results.	**Reports** • Display 'criteria used' in report header. • Include patient phone number on reports. • Default to not include masked data in the report.	**Reports – Prompt for Masked Data** If applicable, display a prompt to ask the user (as per their permissions) whether or not to include masked data in the report.
Medication dosage Set quantity of medication to mandatory.	**Medication List** • Display the patient's current (as defined in the service provider product) medication list in the patient summary. • Distinguish between current (active) and previous prescriptions.	**Medication List** Display the medication list in chronologically descending order.
Immunizations In Office For immunizations performed in the office, set fields for date, lot/batch, route and site to mandatory.	**Immunization reactions** Recognize immunization components as drugs so allergic reactions to immunizations can be coded.	**Referral favourite list** Sort the physician list by region and specialty within region
Masked Data Masked data can only be displayed if mask is explicitly overridden. (i.e., the glass is broken).	**Immunizations In Office** For immunizations performed in the office, set expiry date to mandatory.	**Vaccination Query template** Annually, at the beginning of September, run a recall on all patients eligible for an influenza vaccination who have not had one from April onwards in the current year. This allows clinics enough time to order the correct quantity and vaccination from the health unit.
Student/Resident authority It is mandatory that the physician must explicitly designate authority to each student/resident. (Initially, set each student/resident's access to "cannot prescribe or sign off any aspect of the chart" but allow physician user to be able to modify this default to be appropriate for the specific student/resident.)	**Vaccination Query template** In the query, include: those who have not had an influenza vaccine; those who have not had pneumovax (23 valient).	
File sign off Attachments in the inbox must be reviewed before deletion (or before the attachments are signed off in the chart record).	**Special Authority Forms** Display complete list of specific forms for the given condition and/or medication.	

Functional Requirements - Clinical		
Default (Non-modifiable)	**Default (Modifiable)**	**Recommendation**
Chart sign off Everything entered into the patient's medical chart must be signed off by a physician.	**Similar Patient Name** Set similar patient name alert and phonetic search (e.g., Soundex and spelling) to "on"	
Reporting to replication CDM Toolkit reports At minimum, include: 1. Monthly Recall Report (CDMREP0001) 2. Profile Report(CDMREP0002) 3. Run Charts (CDMREP0003) 4. Data Extremes (CDMREP0004) 5. Patient List (CDMREP0005) 6. Patient Education (CDMREP0006) 7. CHF Key Measures (CDMREP0008) 8. Diabetes Key Measures (CDMREP0009) 9. Patient History (CDMREP0010) Data Entry Summary (CDMREP0011)	**Reporting - CDM Toolkit reports** Minimum set specified only; vendor can go beyond this list.	
Controlled prescriptions Capture non-printable prescription information in the chart in the same manner as any printable prescription.	**Prescriptions** Turn 'on' any features that would tamper-proof the printed prescription (e.g., include number of prescribed items; "end of Rx" line, etc.)	
Deactivated Records Access Mechanism for accessing archived record must not require intervention of service provider.	**Prescriptions** Set 'reason for discontinuation' to mandatory. If the reason for discontinuation is related to an allergy or intolerance, then the user must be prompted or directed to the allergy/intolerance functionality so that such information is appropriately captured.	
	ICD9 and SNOMED codes Display both	
	SOAP Note structure Structure the SOAP format in the logical clinical order (e.g., S-O-A-P)	
	Age Calculation/Display If a patient is under three years of age, display the age in months.	
	Patient Summary Include medications on patient summary screen.	

Functional Requirements - Clinical		
Default (Non-modifiable)	**Default (Modifiable)**	**Recommendation**
	Decision Support Service Providers must provide training to physicians on what is available in terms of decision support. It is preferred that all decision support alerts and reminders to be set to 'on'. If not all decision support elements are immediately set, a plan must be initiated with the practice to turn them on over a definite period of time. Decision support can seem overwhelming initially however; the number of alerts and reminders will decrease to become manageable as they are dealt with. Evidence based templates, flow sheets, and protocols/care plans are based upon the British Columbia guidelines and should be provided in complete format in order to facilitate the optimal care of patients. If users are able to modify these important aides to care – especially removing portions to simplify – patients are bound to receive suboptimal care because care gaps will be created.	
	Decision Support Reminders Alert user to every drug interaction. Suppress duplicate warnings that would otherwise occur, e.g., with a tapering prednisone dose	

Functional Test Scripts – Privacy/Security		
Default (Non-modifiable)	**Default (Modifiable)**	**Recommendation**
Audit Log Ensure MOA role is not able to view the audit log. Ensure physicians can display a patient-specific view of the audit log but not a physician-specific view of the audit log for physicians other than themselves (Note: physician system administrator would have different settings)	**Audit Report** Include 'criteria used' in report header.	**Audit Log** Display audit information in chronological order, most recent first.
Masking Upon emergency viewing, re-establish masking after the session.	**Masking** The duration of unmasking should be set for an interval period of the logon session.	**Annotations and Corrections:** Display in chronological order, most recent first.

Functional Test Scripts – Privacy/Security		
Default (Non-modifiable)	**Default (Modifiable)**	**Recommendation**
Masked – Display notification When there is masked information in the chart, display a prominent alert/indication when anyone accesses the chart to inform them of this.	**Masked data printing** When printing patient data, default to "masked data not shown"	
Logging Administrator must not be able to turn off aspects of the logging.	**User Access** Set access level to the minimum (no access) for all users. Administrator to add sets of privileges as required. This will ensure that security and privacy are maximized and only intended individuals have desired access.	

Functional Test Scripts - Technical		
Default (Non-modifiable)	**Default (Modifiable)**	**Recommendation**
Access Privileges Admin Userid must not be shared (the same admin userid used by all administrators) as it results in anonymous access. Security features must be used to grant specific access to userIDs that correspond to identifiable individuals. The "Administrator" userid should then remain unused. This security configuration must be established.	**Workstation security** After a maximum of 15 minutes of inactivity, the session must be terminated or require re-authentication.	**Business Continuity Copy (BCC)** Download data once per day.

Functional Test Scripts - Scheduling		
Default (Non-modifiable)	**Default (Modifiable)**	**Recommendation**
	Reason for Visit Prompt for office staff to document presenting problem / reason for visit when booking appointment.	Keep all appointments as part of record for a minimum of 3 years.
	Double Booking Turn on capability	
	Non-patient appointments Turn on functionality to schedule non-patient appointments for providers.	
	Patient Appointments Display other scheduled appointments in chronological order by appointment date, soonest first.	
	Appointment history Display all cancelled, rescheduled, and no-show appointments in the appointment list.	

Functional Test Scripts - Scheduling		
Default (Non-modifiable)	**Default (Modifiable)**	**Recommendation**
	Scheduled Appointments Display/Print individual patient appointments in chronological order by appointment date, soonest first.	
	Provider Schedule Set to print with individual patient names.	
	Clinic Hours Use the utility or feature that identifies statutory holidays/weekends	

Functional Test Scripts - Billing		
Default (Non-modifiable)	**Default (Modifiable)**	**Recommendation**
Mandatory Fields Fields, which would result in a rejection of the claim by MSP when left blank, must be set to mandatory.	**½ code billings** Set higher coded value to 100% and lesser coded value to 50%.	
Gender Specific and Procedure Claims Perform all field checking relevant to diagnoses	**Multiple codes** For multiple services billed on the same visit, an alert to prevent duplicate diagnostic codes should be provided.	
Out of Province Claims Set the address field to mandatory	**Locum billing** Set permissions so that locums cannot change the percentage of reimbursement assigned to them.	
WCB claims Appropriate WCB form fields must be set to mandatory.	**Age specific codes** Automatically reset based on proper age (e.g., office visit fee code series).	
	Previous Claims Display historical view in chronological order by service date, most recent first.	
	Third party Invoices Include original amount of invoice if price has been adjusted.	
	Full Service Family Practice Incentive Program Display diagnostic codes for condition-based payments.	