



PITO-Qualified EMRs Standard Functionality

Standard EMR Functionality

The following is an abbreviated list of features offered by **all PITO-Qualified EMR vendors**. This is not a comprehensive list, as there are many other requirements detailed in the Master Standing Agreement (MSA) with the PITO-Qualified vendors. Additionally, all vendors offer unique features that exceed this list of standard requirements.

Data Management

- Matches information received to the patient's EMR
- Reconciles test results with orders
- Highlights mandatory data fields
- Enables entry and display of both metric and imperial measures
- Merges and unmerges duplicate records
- Assigns unique internal patient identifier
- Deactivates and archives inactive patient records
- Integrates between EMR components to eliminate duplicate data entry

Documentation

- Supports free-form notes or adds own user-defined canned text
- Documents medications, labs and procedures done outside the clinic
- Modifies or creates templates
- Faxes documents and attaches faxes to patients' charts
- Prints patients' charts chronologically

Patient Registration

- Supports patient search using various criteria (e.g. name, PHN)
- Provides notification of duplicate charts
- Displays Name alerts for similar patient names
- Documents patient relationships to other patients (e.g. families)
- Records child custody/guardianship
- Automatically calculates age and deceased age
- Allows deletion of incorrect patient records and tracks reason the file was deleted or inactivated



Scheduling

- Defines appointment types (e.g. complete physical, advanced access, etc.)
- Reschedules appointments without losing data
- Allows double-booking

- Automatically links appointments with patients
- Defines individual hours per physician or global clinic hours
- Easily transfers appointments to another clinician
- Allows scheduling of non-patient appointments (e.g. hospital rounds)
- Searches for available appointments based on expected needs
- Allows multiple users to view/update schedule simultaneously
- Permits multi-physician view
- Displays pertinent patient data at point of scheduling
- Allows documentation of presenting problem during booking
- Records referring physician
- Documents walk ins
- Identifies and prints all scheduled appointments for a patient
- Shows appointment status (e.g. in waiting room, in exam room, no show)
- Notifies of conflicts
- Prints schedules: daily, weekly or monthly
- Retains appointment history and audit trail



Provide Care

- Provides a single, summary overview of patient data
- Summarizes list of recent and reoccurring encounters
- Separates active and inactive problems
- Displays patient alerts
- Enables e-Signature of charts and orders
- Allows supervising physician to sign-off students' notes

Assess/Manage Current Problem

- Enters clinical notes in a structured SOAP format
- Provides clinical tools that support clinical documentation and decision making
- Records and updates/removes patient allergies, intolerances and adverse reactions
- Graphs and prints coded & measured elements from a patient's chart over time with normal ranges
- Enables viewing of outstanding orders
- Replicates CDM toolkit flowsheet

Immunizations



- Creates immunization entries for a patient or groups of patients
- Provides mandatory fields for immunizations
- Records adverse reactions to immunizations
- Provides viewing and printing of patients' complete immunization history

Orders

- Displays order diagnostic imaging and labs
- Prints requisitions with patient's instructions
- Creates and prints labels
- Shows interactions for drug/lab and drug/procedures

Medication Management

- Maintains individual patient medication lists and dosages in a medication profile
- Displays and sorts historical medication data using a user-defined criteria
- Enables prescription writing and printing: print multiple Rx on a single print out
- Supports prescription writing, including: recommended dosage, route, refills, repeats
- Provides paper prescriptions that show provider/clinic details as per CPSBC requirements
- Searches medications by generic or brand name, category/class
- Creates "favourites" list for quick prescribing
- Allows entry of drugs not in standard formulary
- Permits individualize dosing; allows tapering dosage
- Allows customized directions for taking medication
- Records discontinued medications and records reason
- Generates special authority forms



- Enables drug interaction checking:
 - Drug to Drug
 - Drug to Disease
 - Drug to Allergy
 - Drug to Procedure
- Provides quick renewal of medications from a patient's list of existing medications
- Allows ability to document that patient or pharmacy has been notified of follow-up associated with medication renewals

Consults

- Provides customizable referral letter templates
- Pre-populates referral request letters with a minimum set of existing patient data
- Allows indication of urgency of referral
- Stores a list of care providers for completing referrals

Non-Visit Encounters

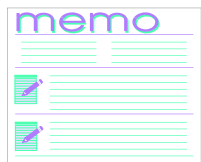
- Tracks telephone calls or contact attempts in the patient record
- Documents that a non-visit encounter has occurred
- Documents any provision of care or follow-up planning that occurred during a non-visit encounter
- Prints requisitions/orders as a result of non-visit encounter care or follow-up
- Generates a referral that is not connected to a patient visit

Review Practice: Queries and Reports

- Enables user-definable patient recall reports and follow-up lists e.g. vaccination deficiencies, overdue tests etc.
- Includes/excludes patient populations from recall list
- Saves a user-generated recall query
- Creates and saves custom practice reports
- Replicates the CDM Toolkit's patient, provider and practice level report

Task Management

- Provides a task management area (e.g. dashboard) where users can manage/ forward tasks and active items, such as: messages, personal "to-do's", active referrals, prescription renewals and active lab results
- Automatically updates dashboard information
- Allows sharing of tasks, results, etc. between providers in a shared practice
- Creates groups of users for managing tasks



Results Management

- Displays lab test results in tabular form and indicates where results originated; results can be filtered and sorted
- Highlights abnormal test results at the lab test and report levels; flags abnormal and critically abnormal results
- Alerts clinician of a changed test result; notifies of a new test; maintains old results

- Summarizes historical lab results
- Supports electronic sign-off for all results/reports
- Automatically creates a review task for the appropriate user when a new DI report and/or image is received
- Stores manually transcribed DI text results
- Captures notes for an image or report that are attached to a patient's record and stored

Referrals Management

- Manages active referrals with a referral list
- Logs when a referral has been sent and to which provider(s): includes date and time stamp
- Allows sending (or cc:) of a consult letter or report to multiple providers (at least 5)
- Attaches received referral/consult letter to patient's record
- Maintains an historical patient-based record of referrals

Manage Billing

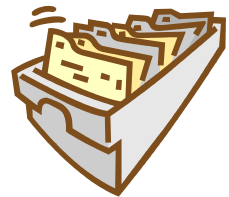
- Maintains records in accordance with the MSC Payment Schedule
- Accommodates Full Service Family Practice Incentive Program
 - Automatically transfers scheduling appointment information to billing
 - Provides fee schedule lookup by code, description, and alternate description
 - Translates diagnostic codes for billing purposes with ability to handle ad-hoc changes for non-matching items
 - Gives user-defined billing codes and items
- Permits direct manual entry of billing items
- Allows half-code billing
- Permits multiple code billing at once
- Allows for billing of multiple payees and providers
- Supports locum billing
- Provides bill fee codes for managing labs and medications
- Captures public and private billing as one visit
- Archives/deletes incorrect billing transactions after rejection
- Supports automated provincial billing resubmission
- Checks out of province registration numbers for format validity for inter-provincial billing
- Allows billing for ongoing hospital care
- Allows billing for multiple hospital visits in one day



- Allows billing for Emergency Department and other off-site codes
- Supports blended funding billing
- Maintains a list of BCMA-recommended fees for third party/private billings
- Electronically submits WCB and ICBC forms and invoices
- Displays an historical view of previous claims and results by patient
- Provides error checking and claim validity warnings prior to MSP submission
- Allows batch claim submissions
- Supports more than one specialty code
- Provides automated reconciliation and claim resubmission
- Allows multiple provider registration numbers and permits timing to be assigned to each number
- Provides a preloaded provincial fee schedule
- Maintains historical fee schedules for the preceding 365 days
- Permits direct patient billing for private fees and prints patient invoices at point-of-sale
- Provides open item (detailed) aged receivable listing
- Maintains 30/60/90 day reports available for Accounts Receivables

Manage Paper

- Attaches digital files to patient records
- Creates flags for follow-up appointments based on information in an attached file
- Enables sign-off on an attached file or transcribed text
- Tracks manual and automated transcription by person, date, and time



Clinical Decision Support

- Integrates reference support into the clinical workflow
- Provides tools for creating templates and flowsheets
- Displays reminders of pending or missed actions that need attending
- Displays reminders that an intended action may not be indicated for a particular patient
- Provides the ability to follow links to current decision supporting evidence
- Provides the ability to add your own clinical decision support
- Provides the ability to turn off decision support

Templates and Flowsheets

- Provides templates/flowsheets, alerts and reports following BC's Clinical Practice Guidelines for:
 - Chlamydia, gonorrhoea, HIV, syphilis, and tuberculosis
 - Arthritis
 - Asthma
 - Chronic Kidney Disease
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Congestive Heart Failure (CHF)
 - Dementia
 - Depression
 - Diabetes
 - Hepatitis B and C
 - Hypertension
 - Prevention
 - Immunizations
 - Pregnancy
 - Obesity screening and management



For more information, please contact PITO:

115-1665 West Broadway
Vancouver, BC
V6J 5A4
Tel: 604.638.2946
Email: info@pito.bc.ca
www.pito.bc.ca