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Proposer's Name: _____

RFP No: G099-0922-10

ADDENDUM VI-A

FUNCTIONAL REQUIREMENTS

Mental Health
Electronic Health Record System

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FUNCTIONAL REQUIREMENTS RESPONSE INSTRUCTIONS

The Functional requirements set forth in this Addendum IV-A - Functional Requirements, for the Mental Health EHR RFP are contained in a Microsoft Excel workbook and is designed to be a self-scoring matrix. The matrix has been designed to require a single response in the appropriate Response Column How Met or Avail. for every numbered requirement within each respective section. Only one entry per numbered requirement is permitted. Proposer shall not place responses in columns that are shaded or unnumbered, alter, insert rows or add data to the matrix.

Complete and submit information as requested for each and every required tab. The tabs are organized first by functional area and second by supporting process.

IMPORTANT: Proposer must not leave any numbered requirement response column blank within each respective section. Failure to provide a response to any numbered requirement will be deemed "Non-Responsive." Multiple responses to any numbered requirement will also be deemed "Non-Responsive." Responses that are deemed "Non-Responsive" will result in a zero (0) point score or may, in County's sole discretion, result in disqualification or elimination of the proposal.

For each numbered requirement, select one of the following for Response Column "How Met". The definitions for this column are as follows:

* **Standard (Std.)**

  Requirement can be met...
  ● with a feature that exists as part of the system's existing feature set
  ● through the use of configuration or customization tools that already exist within the system, but without any programming or changes to program code base (e.g. using a built-in tool to build custom local forms, reports or workflows would be acceptable)
  ● through the use of 3rd party products bundled as part of a typical or standard installation (e.g. a 3rd party report writer)
  Note: For all requirements marked as "Standard feature," fill out "Avail." column.

* **Minor Modification (Min.)**

  Require LESS THAN 80 hrs of work: Requirement can be met...
  ● by spending up to 80 hours modifying or extending the proposed solution
  ● by making changes to the baseline product code, including the use of custom programming
  ● by incorporating 3rd party products that are not included as part of a standard installation
  Note: All costs associated with system modifications, both one-time and on-going maintenance, must be provided as separate line items in the cost proposal. All modifications must be fully supported by the vendor and supported in the system upgrade process.

FUNCTIONAL REQUIREMENTS RESPONSE INSTRUCTIONS

* **Major Modification (Mjr.)**

  Require MORE THAN 80 hrs of work: Requirement can be met...
  - by spending over 80 hours modifying or extending the proposed solution
  - by making changes to the baseline product code, including the use of custom programming
  - by incorporating 3rd party products that are not included as part of a standard installation

  Note: All costs associated with system modifications, both one-time and on-going maintenance, must be provided as separate line items in the cost proposal. All modifications must be fully supported by the vendor and supported in the system upgrade process.

* **Not Available (N/A)**

  Requirement is not and will not be met by proposed solution

For each numbered requirement to which "How Met" is Std., select one of the following for Response Column "Avail". The definitions for this column are

* **Production (Prod.)**

  Feature is installed and currently being used at similar client sites as part of the standard production product.

* **Beta (Beta)**

  Feature is installed and being used in at least one client environment (may be running in client test environment) and is scheduled to be incorporated into standard production product by 5/31/11.

* **In Development (Devl.)**

  In development: feature is being designed or built and is scheduled for general release into standard baseline production product by 5/31/11. Design documents may be requested.

In addition, please provide comments that may better allow the County to evaluate your response:

* **Comments**

FUNCTIONAL REQUIREMENTS RESPONSE INSTRUCTIONS

Provide any comments or concerns on the requirements in the section. These comments will not be used for evaluation but may be referred to for clarification by the County evaluation team.

Functional Category Title	Section #	Description
Screening	1.0	Consumer Portal
	2.0	Call Intake
	3.0	Application/Pre-Registration
	4.0	Eligibility
	5.0	Referrals
	6.0	Financial Screening
	7.0	Level of Care/Medical Necessity

How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/A for Not Applicable

Requirement		Prior.	How Met	Avail.	Comments
1.1 Consumer Portal: Maintaining a website that offers information to the public, potential, or active consumers. For the public, the portal establishes a 'web presence" that provides information – description of the services that SCMH offers, the location of facilities, and allows access to outreach and educational materials, such as provided through the Network of Care. For a consumer actively seeking services, the consumer or their caregiver can request an intake/assessment or complete form prior to an appointment. A consumer in treatment could check appointments, make payment, or access other services that promote their well-being, such as secure messaging, chat boards, search engines, and educational content.					
R3508	The system shall provide a portal that enables the public to access information about and to apply for services.	D			
R4362	The system shall provide a portal that enables an active consumer to register for additional services on-line.	HD			
R3509	The system shall support online completion and submission of various forms, including but not limited to application, enrollment, and registration forms and customer satisfaction surveys.	HD			
R3510	The system shall automatically populate appropriate forms (e.g., intake assessment) from data entered online.	D			
R3517	The system shall support online bill payments by active consumers.	HD			
R3518	The system shall permit active consumers to view the status of their account (e.g., balance).	HD			
R3520	The system shall support chat rooms and/or forums for active consumers.	D			
R3521	The system shall enable an active consumer to send a secure message to their assigned counselor or therapist.	HD			
R3546	The system shall permit the posting of information/ education, including County-specific information, for the general public and active or prospective consumers (e.g., education and prevention, services, programs, locations, hours of operation, and contact information).	HD			
R3547	The system shall permit the posting of documents that may be downloaded in PDF format (e.g., applications and satisfaction surveys).	HD			
R4352	The system shall provide the capability for a consumer to develop, update, and maintain an individual Wellness Recovery Action Plan (WRAP).	HD			
R3512	The system shall permit active and prospective consumers to request an appointment for services.	HD			
R3513	The system shall capture requests for various appointment types, including drug testing, intake assessment, appointment with assigned counselor/therapist for active consumers, etc.	HD			
R3514	The system shall support: online viewing of scheduled appointments by active consumers.	HD			

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Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/A for Not Applicable

Requirement		Prior.	How Met	Avail.	Comments
R3515	The system shall enable active consumers to request changes to, or cancellation of, one or more previously scheduled appointments	HD			
R4259	The system shall support a consumer's ability to conduct an online search for providers by specialty, gender, and geographic location (e.g., zip code).	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.2 Call Intake: Accepting consumers' and other individuals' inquiries (both written and verbal), documenting consumer and call information, and responding appropriately to the inquiry on a timely basis. Contact is usually established in one of three ways: through the 1-800-Access Line, attended 24 hours a day; by direct contact with a county clinic; or via direct contact with a contracted provider. Contact may be routine, urgent, or emergent. Inquiries can be related to County-provided services, referrals, directions, eligibility, benefits, change of address, complaints, claim filing, or an emergency situation. Solano County Mental Health is centralizing intake through the Managed Care/Access line that is conducts an intake screening. Screening is facilitated by medical and financial eligibility information provided by the consumer. Information gathered by the Access team is facilitated by online client screening forms in ShareCare and includes relevant clinical and financial information. A determination is made by the Access team member whether the client requires services from the crisis system, referral for outpatient services, or referral to other community resources. Crisis is the initial point of authorization for inpatient services. Hospitals can go directly to Crisis for authorization.					
R3254	The system shall capture service request related information for inquiries coming in through a centralized 1-800-Access Line (at the time of call intake), direct contact with a County clinic, or direct contact with a contract provider.	HD			
R3255	The system shall allow a user to route crisis contacts to crisis workers and requests for routine care to outpatient clinics.	HD			
R3256	The system shall capture information from consumer calls pertaining to complaints, grievances, appeals, and compliments, including disposition of such calls.	HD			
R3257	The system shall permit real-time data checking and data entry while a user is on the phone with a consumer, prospective consumer, or related party.	HD			
R3258	The system shall provide the ability to capture, maintain, update, and report on State-mandated California Alcohol and Drug Data System (CALOMS) demographic data.	HD			
R3259	The system shall flag and track homeless consumers	HD			
R3260	The system shall flag and track consumers at imminent risk of becoming homeless	HD			
R3261	The system shall flag and track consumers, including associated aggregate data, using Homeless vouchers	HD			
R3262	The system shall ensure that the demographic information for a consumer includes ZIP code and census tract.	HD			
R3263	The system shall flag and track active consumers who have not received services for a specific date range.	HD			
R3264	The system shall flag and track consumers currently receiving Adult Protective Services (APS)	HD			
R3265	The system shall flag and track consumers by service program.	HD			
R3266	The system shall list dually-diagnosed consumers	HD			
R3267	The system shall flag and track consumers currently receiving services from Social Security Advocacy Team	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3269	The system shall provide online consumer screening forms that capture information on access needs, presenting problems, and other clinical information required to assist in determining whether the consumer requires crisis services	HD			
R3271	The system shall capture the disposition of the call, including documentation of consumer situation and status relative to disposition decision.	HD			
R3273	The system shall capture and maintain all appropriate information on the call or contact (e.g. caller name, phone number, language requirement, gender, ethnicity, type of call, etc.).	HD			
R3274	The system shall gather the following information on each call received for reporting purposes: Attributes of caller (i.e., gender, ethnicity, age, location), Non-crisis support, Requests for 5150s, Assessments (child and adult), Inpatient admissions (child or adult; category of admission).	HD			
R4263	The system shall track the duration from the time of a consumer request for service to the disposition of that request to include: request to resulting first assessment, first appointment and/or first face to face visits with a provider.	HD			
R3275	The system shall record the number of calls received through the County 800# (i.e., operated by the MCU/Access Team). (Refer to California Code of Regulations Title 9. Rehabilitative and Developmental Services, Division 1. Department of Mental Health, Section 1810.405.)	HD			
R3277	The system shall track and monitor the status of unresolved inquiries or complaints until the call is completed or the case is closed.	HD			
R3278	The system shall flag and track consumers recently referred to outside services.	HD			
R3279	The system shall capture how and where consumer was transported to the admitting facility, including but not limited to: Law Enforcement, System of Care staff, Ambulance, Referred by Organization, Self, etc.	HD			
R3281	The system shall capture and report on all information required by Federal, State, and local agencies, such as penetration rates, telephone access, and CSI data, to assess performance of the call intake process and improve the quality of service.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.3 Application/Pre-Registration: The process of completing a group of initial administrative functions necessary to provide mental health services to an individual, such as completion of initial request for service (i.e., client demographic and financial resources). For drop-ins, this will be the consumer filling out the paperwork at the front desk of the clinic. For Crisis, this will include the ability to obtain initial authorization for a consumer (i.e., Mobile Crisis, inpatient). This information is captured on the Managed Care Form.					
R3180	The system shall capture initial consumer demographic and financial information for individuals requesting service at the time of pre-registration or application/enrollment.	HD			
R3181	The system shall automatically provide all pre-registration or application/enrollment information to registration if the individual becomes an active consumer.	HD			
R3182	The system shall permit staff to assign consumers to programs.	HD			
R3183	The system shall permit staff to assign funding to programs.	HD			
R3184	The system shall permit the embedding of an automatic link to the Megan's Law website to verify status of consumer as a sex offender.	HD			
R3185	The system shall permit authorized staff to display on their workstation and/or print language specific bilingual (English and Spanish) enrollment letters, provider change letters, or other letters as identified.	HD			
R3186	The system shall support kiosks (e.g., in waiting room areas) with secure access that allow consumers to enter application data themselves.	D			

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Requirement		Prior.	How Met	Avail.	Comments
1.4 Eligibility: Determination of consumer eligibility (i.e., does a consumer meets various payer sources' eligibility requirements). Eligibility criteria for benefits may be based on a client's medical necessity, financial status, age, diagnosis, court referral, etc. A client may not qualify for one program, but may qualify for an alternative program, depending on payor-specified criteria. Client information is initially verified with established eligibility criteria for various payors to determine qualification. Client episode or encounter information is cross-referenced throughout the treatment process with eligibility information for appropriate authorization and payment. A client can belong to more than one reimbursement group with respect to coordination of benefit process. Grouping can be based on criteria such as insurance, age, grant status, legislation, and so forth. If a client is determined to be eligible, then an assignment of eligibility period is determined with begin/end date. Other eligibility information may include Medi-Cal mandated benefits, co-payment, deductible, co-insurance, coordination of benefit (COB), subrogation (workers compensation), exclusions, and other limits/restri					
R3189	The system shall permit users to define program-specific clinical and financial eligibility criteria.	HD			
R3190	The system shall automatically alert staff when a consumer has met clinical eligibility criteria that qualifies them for a specific program.	HD			
R3192	The system shall indicate whether consumer has provided current proof of income.	HD			
R3193	The system shall support consumer eligibility determination for Medi-Cal.	HD			
R3194	The system shall support consumer eligibility determination for Drug Medi-Cal.	HD			
R3195	The system shall support consumer eligibility determination for Medi-Cal/Medicare crossover.	HD			
R3196	The system shall support consumer eligibility determination for Medicare.	HD			
R3197	The system shall support consumer eligibility determination for specific County Grant and contract funding.	HD			
R3198	The system shall support consumer eligibility determination for General Relief.	HD			
R3199	The system shall support consumer eligibility determination for CalWORKs/CalWIN.	HD			
R3200	The system shall support consumer eligibility determination for Healthy Families.	HD			
R3201	The system shall support consumer eligibility determination for private insurance.	HD			
R3202	The system shall provide the ability for a designated user to access the Medi-Cal Eligibility Data System (MEDS) to determine if a consumer is eligible to receive Medi-Cal services.	HD			
R4364	The system shall provide online, real-time eligibility verification for non-Medi-Cal payers who support this capability (e.g., Partnership Healthplan).	HD			
R3206	The system shall support eligibility loading for Medicare.	HD			
R3207	The system shall support the electronic downloading and integration of eligibility data for all health plans and insurers with whom the County contracts.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3209	When the State MEDS system has been accessed, the system shall update the Eligibility Verification Code (EVC) in a consumer's Medi-Cal insurance record.	HD			
R3211	The system shall capture consumer eligibility information from a variety of sources (e.g., Medicare, Medi-Cal, Partnership, private insurance), provide tools for designated users to verify benefits, and update the benefits for which a registered consumer is eligible.	HD			
R3213	The system shall automatically populate consumer insurance fields when no prior eligibility has been determined.	HD			
R3214	The system shall automatically update consumer insurance information when the eligibility status has changed, including retro-active updates for consumers previously served.	HD			
R3215	The system shall provide recommendations as programs/plans to fund services provided to a consumer based on consumer needs, financial ability, and Medi-Cal eligibility.	HD			
R3216	The system shall support eligibility processing for all health plans and insurers with whom the County contracts.	HD			
R3217	The system shall alert all appropriate parties involved in a consumer's care of Medi-Cal eligibility status changes, either prospective or retrospectively.	HD			
R3218	The system shall identify consumers who have lost their insurance coverage.	HD			
R3219	The system shall generate a notification when a consumer's annual financial evaluation expires.	HD			
R3220	The system will prompt staff to print County selected forms to give to the consumer at the conclusion of the eligibility/financial assessment (e.g., the Advanced Beneficiary Notices).	HD			
R3221	The system shall maintain and update a consumers' eligibility information to include consumer's qualification or disqualification status, financial and employment status, and revised eligibility criteria.	HD			
R3222	The system shall maintain Medi-Cal eligibility for all individuals identified in the monthly Medi-Cal download from the State, not just individuals who are enrolled as consumers. Similar capabilities should be available for Medicare and health plans with whom the County contracts.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3223	The system shall permit manual on-line reviewing and updating of insurance records for consumers with special handling conditions including: a partial eligibility match requiring investigation, Medi-Cal Share of Cost responsibility, CMSP eligibility, other State aid codes, Medicare, private insurance, and Medi-Cal consumers with a different responsible county.	HD			
R3224	The system shall track consumer eligibility to a program/service/plan.	HD			
R3225	The system shall maintain multiple eligibility/program statuses.	HD			
R3226	The system shall maintain multiple eligibility sub-programs to ensure that ineligibility for one service does not override eligibility for other services.	HD			

How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
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Requirement		Prior.	How Met	Avail.	Comments
1.5 Referrals: Referring a client to another provider for services. SCMH must track both outgoing (made from) and incoming (made to) referrals. Referrals can be to/from network providers, community based organizations (CBOs), and other institutions (e.g., state hospital, IMDs). In addition, the referral process between SCMH and other parts of H&SS may need to be formalized, specifically between SCMH and the FQHC that will be providing Adult behavioral health services at Fairfield and Vallejo Outpatient Clinics.					
R4350	The system shall support the referral process of sending and receiving a client from one provider to another for services. This includes the tracking of outgoing and incoming referrals made to/from SCMH, as well as to/from other agencies in the County, network providers, community based organizations (CBOs), and other institutions (e.g., state hospital, IMDs).	HD			
R2932	The system shall support electronic referrals.	HD			
R3410	The system shall automatically generate all forms that must be completed to support referrals to CBOs and network providers.	HD			
R3772	The system shall have the capability to receive electronic referrals.	HD			
R3773	The system shall track consumers by referring organization.	HD			
R3774	The system shall record, acknowledge, and track incoming referrals.	HD			
R3776	The system shall track all incoming referral information.	HD			
R3777	The system shall send referral confirmation when a referral has been received.	HD			
R3778	The system shall document, track, and report on the disposition of an incoming referral.	HD			
R3779	The system shall automatically notify external referral sources of assessment results/disposition and enrollment status.	HD			
R3780	The system shall capture patient financial liability at the time of referral.	HD			
R3782	For accepted consumer, deciding which clinician will serve as the lead therapist or counselor, and adding the consumer to the clinician's case load.	HD			
R3783	The system shall match consumer to clinician using multiple variables determined through the selection of user-defined criteria (e.g., provider location, specialties, non-English language capability, etc.).	HD			
R3784	The system shall assign staff to a consumer /referral by a user at the time a referral is received.	HD			
R3787	The system shall capture and maintain other user-defined information on community resources.	HD			
R3788	The system shall capture and maintain community resource information into a searchable database integrated with the main system that can be filtered based on user-defined criteria.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3789	The system shall store community resource information in a way that keeps these records separate from the list of network providers, or in a separate table that has the same lookup and tracking capabilities of the provider referral database.	HD			
R3790	The system shall have the ability to transfer appropriate referral information to assessment and treatment plan forms.	HD			
R3791	The system shall record that a consumer has been referred to another provider (e.g., housing, social services, primary care) along with any supporting information.	HD			
R3792	The system shall streamline sending health record information to outside providers (e.g., the consumer's primary care provider).	HD			
R3793	The system shall have the capability to generate electronic referrals.	HD			
R3794	The system shall support the issuance and tracking of service referrals to Network Providers.	HD			
R3795	The system shall validate CalOMS discharge status prior to completion of referral out.	HD			
R3796	The system shall document, track, and report on the disposition of an outgoing referral (e.g., whether consumer was seen by the provider or organization to which she/he was referred).	HD			
R3797	The system shall provide the capability for authorized users to send referrals via email or e-fax.	HD			
R3548	The system shall support electronically sending/receiving referral packets.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.6 Financial Screening: Process of collecting financial information from a client to determine the specific client charges for services. A financial screening occurs at the time of the initial intake and annually thereafter. Ability to pay is determined by a sliding scale and is based on variables such as gross household income, size, and assets. Usually applicable to lower income consumers, fees may be calculated according to the Uniform Method for Determining Ability to Pay (UMDAP) or another method, depending on the payer source (e.g., insurance co-insurance, deductable for Medicare, share-of-cost (SOC) amount for Medi-Cal).					
R3997	Developing annual fees for each program with placeholders for cost of service, State Maximum Amount, or billed charge, using various methodologies, including creating sliding scales based on UMDAP. Maintaining accurate and up-to-date historical and current information on payer-specific or County charges for all services rendered and programs offered to clients.	HD			
R4273	The system shall track Universal Method Determining Ability To Pay (UMDAP) liability for billing purposes.	HD			
R4274	The system shall determine Universal Method Determining Ability To Pay (UMDAP) liability by "family units" and individuals.	HD			
R4275	The system shall permit establishment of the UMDAP year and family members for the family group.	HD			
R4276	The system shall permit consumer payment options such as co-pays or Universal Method Determining Ability To Pay (UMDAP) amounts.	HD			
R4280	The system shall calculate differential pricing/payment based on program/plan providing the service.	HD			
R4281	The system shall indicate share-of-cost and co-pay information by plan/program.	HD			
R4282	The system shall track clearing of Medi-Cal share of cost for both MH and non-MH services and coordinate with State annual UMDAP requirements.	HD			
R4283	The system shall immediately update and report consumer financial accounts to include Share-of-cost.	HD			
R4284	The system shall immediately update and report consumer financial accounts to include Co-payment.	HD			
R4286	The system shall automatically apply a consumer's payment history against their share of cost.	HD			
R4287	The system shall automatically calculate a consumer's fulfillment of their share of cost.	HD			
R4289	The system shall permit a variety of consumer income verification practices depending upon the service or program parameters.	HD			
R4290	The system shall automatically calculate sliding fees.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R4291	The system shall generate Advanced Beneficiary Notices (ABNs) and track whether consumer signatures have been obtained. (Note: ABNs mostly include standard language but include some consumer-specific information such as name and medical record number.)	HD			
R4292	The system shall automatically generate Advanced Beneficiary Notices (ABNs) for Medicare beneficiaries.	HD			
R4293	The system shall automatically populate Advanced Beneficiary Notices (ABNs) with consumer name and Medical record number.	HD			
R4354	The system shall provide the capability for an authorized user to maintain accurate and up-to-date historical and current information on payer-specific or County charges for all services rendered and programs offered to consumers.	HD			

How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
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	Requirement	Prior.	How Met	Avail.	Comments
1.7 Level of Care/Medical Necessity: Initial assessment of a consumer to a) determine whether they have a mental health diagnosis (medical necessity) and b) determine appropriate level of care (the process of determining the necessity, appropriateness, and efficacy of service provided to the consumer). SCMH refers to this process both for Screening (i.e., the initial entry of a client into the County for mental health services, contact is via the Managed Care Access team following guidelines to asses for medical necessity/LOC determination) and Intake (i.e., the initial face-to-face intake between a clinician and the client).					
R3937	The system shall capture all necessary information for either inpatient or outpatient services according to DMH regulations. (See Title 9, California Code of Regulations, Chapter 11, Medi-Cal Specialty Mental Health Services, Section 1830.210 (Under 21 Years), Section 1830.205 (Outptient), and Section 1820.205 (Inpatient).)	HD			
R3939	The system shall support authorizations for treatments and services.	HD			
R3940	The system shall support authorizations for inpatient psychiatric services (PHF), mental health day treatment, and Therapeutic Behavioral Services (TBS).	HD			
R3941	The system shall provide the ability to list the services for which the consumer is eligible and authorized to enroll.	HD			
R3942	The system shall maintain and track service authorizations according to consumer funding. This will include: Medi-Cal, Medicare, Healthy Families, Medically Indigent Adult (MIA), other.	HD			
R3943	The system shall capture patient financial liability at the time of authorization.	HD			
R3944	The system shall permit for the issuance, letter generation, tracking and closing of internal authorizations that the County issues for consumers served at County clinics.	HD			
R3945	The system shall permit for the issuance, letter generation, tracking and closing of authorizations received from health plans and managed care companies authorizing services rendered by County staff.	HD			
R3946	The system shall permit for the issuance, letter generation, tracking and closing of authorizations that the County issues to providers in the provider network as part of the County's role as a Medi-Cal health plan.	HD			
R3947	The system shall support the setting of service limits for each type of authorization, including but not limited to number of visits or days, number of consumer or clinician service hours, number of days or weeks, specific service codes, specific dollar limits, and/or service clusters/packages.	HD			
R3948	The system shall support the definition and enforcement of authorization rules that lockout the provision of services to a consumer based on any user-defined service/consumer/provider/payor combination.	HD			
R3949	The system shall allow for the issuance, letter generation, tracking and closing of a variety of authorization types (e.g. acute inpatient, consumer, outpatient).	HD			

How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/A for Not Applicable

Requirement		Prior.	How Met	Avail.	Comments
R3950	The system shall compare documented services provided to authorized amounts and notify providers and utilization managers of remaining balances and impending authorization expirations.	HD			
R3951	The system shall lockout (during authorization) individual/organizational/private provider services according to the service limits established for that type of authorization or in the case of Medi-Cal/Medicare crossover cases.	HD			
R3952	The system shall permit authorized staff to override lockouts.	HD			
R3953	The system shall permit authorized staff to add, change, or delete services within an individual authorization.	HD			
R3956	The system shall support the State of California Treatment Authorization Request (TAR) process per insurance and payer requirements, including but not limited to: developing the TAR, tracking the status of the TAR (e.g., pending, denied, or approved), and tracking the history of all TARs.	HD			
R3957	The system shall permit authorized staff to print or display the Service Authorization and/or Treatment Authorization Request (TAR).	HD			
R3958	Proactively ensuring appropriate use of services, including establishing medical necessity, obtaining or requiring prior authorizations, obtaining treatment authorizations, and performing prospective/ concurrent/ retrospective utilization review.	HD			
R3959	The system shall identify services that can and cannot be reauthorized.	HD			
R3960	The system shall list services for which the consumer is authorized.	HD			
R3961	The system shall track prospective consumers who have been authorized for services but who have not yet been evaluated or assessed.	HD			
R3962	The system shall update (renew) consumer record and authorize additional services or treatment when required for qualified consumers.	HD			
R3963	The system shall track authorizations issued by third parties.	HD			
R3964	The system shall provide the ability for a user to verify that a program, service, or plan has been authorized, through the provider portal if the user has access to the portal.	HD			
R3965	The system shall permit staff to enter narrative comments regarding authorized treatments or services.	HD			
R3966	The system shall automatically alert the appropriate users (e.g., the authorizing agent, network provider) when authorized services have been depleted.	HD			
R3968	The system shall permit authorized users to suspend authorization of services based on Medi-Medi rules.	HD			

Solano County
Health & Social Services
Mental Health Electronic Health Record (EHR) System

Functional Category Title	Section #	Description
Intake	8.0	Registration
	9.0	Appointments/Attendance
	10.0	Wait List
	4.0	Eligibility
	6.0	Financial Screening
	7.0	Level of Care/Medical Necessity

How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/A for Not Applicable

Requirement		Prior.	How Met	Avail.	Comments
1.8 Registration: Recording client arrival at a County clinic and tracking the status of the visit. Client information, such as demographic, financial, and cultural/social, are captured or updated upon a client's arrival at the clinic, whether scheduled or a walk-in.					
R3362	The system shall support the collection of demographic and other data that is appropriate for the consumer's diagnosis, age, service setting, etc. at the time a consumer registers for service.	HD			
R3363	The system shall be configurable to support consumer focused data collection (e.g., as a consumer is being admitted for alcohol problems, the information system will automatically prompt for particular data items appropriate to the consumer).	HD			
R3364	The system shall prompt the user performing consumer registration for missing data.	HD			
R3365	The system shall during the registration process cross check consumer name against other possible aliases.	HD			
R4371	The system shall allow a user to check eligibility information at registration.	HD			
R3366	The system shall document confirmation of the consumer's information and provide notification to all necessary parties.	HD			
R4370	The system shall log, track, and provide notification to a user of dates when a consumer has been provided and acknowledged key information such as HIPAA Notice of Privacy Practices.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.9 Appointment Scheduling/Attendance: Appointment scheduling is accepting requests for, and to record, the date and time of a consumer's future visit(s), reason for the visit(s), and with which service provider. It is designed to accommodate the availability of consumers, providers, and other resources and, as such, may need to accommodate personal schedule information maintained by providers or resource commitments logged on the master calendar for a Solano clinic. Appointments can be based on a pre-determined time or a first come/first served basis (i.e., walk-ins). Appointments may be individual, group, or a combination of individual and group. Attendance is documenting or recording whether a consumer was present at a scheduled appointment, group, or event, including noting absences and reasons for not being present, such as excused absences. Attendance may also include recording the presence of a consumer who dropped-in at a group or event for which there was no scheduled appointment.					
R3283	The system shall offer a fully integrated appointment scheduling module that allows for rapid entry and retrieval of consumer appointments with staff.	HD			
R3284	The system shall support centralized scheduling for authorized staff throughout the Department (e.g., authorized staff at Vallejo clinic can see the schedule for the Fairfield clinic).	HD			
R3286	The system shall permit authorized users to enter information on staff schedules.	HD			
R3288	The system shall maintain provider profiles, including dates and times a provider is available and not available for consumer appointments.	HD			
R3289	The system shall track counselor/clinician caseload, including actual caseload, recommended maximum caseload, and availability to handle additional cases .	HD			
R3290	The system shall permit adjustments to counselor/clinician caseloads at will.	HD			
R3292	The system shall generate daily and monthly staff schedules organized by user-defined locations, shift, and staff classification.	HD			
R3296	The system shall provide the ability for an authorized user to view staff schedules for staff workload planning.	HD			
R3297	The system shall provide a capability for scheduling groups (e.g., program dependant such as counseling, therapy, etc) and assigning individual consumers to one or more groups.	HD			
R3299	The system shall display in real-time group availability and capacity.	HD			
R3300	The system shall integrate the consumer-signed roster with Progress Notes and automatically apply the appropriate charge(s) to the consumer account.	HD			
R3302	The system shall support multiple program-specific requirements for group structure (e.g., minimum/maximum number of consumers per group).	HD			
R3304	The system shall support schedules organized by provider.	HD			
R3305	The system shall permit authorized staff at one clinic to schedule an appointment for a clinician at another clinic.	HD			
R3306	The system shall provide the ability to search and find the first available appointment for any given provider.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3307	The system shall prompt a user with suggestions for the next available appointment based on the master schedule and appointment parameters.	HD			
R3308	The system shall provide a list of possible times for scheduling education, therapy, and counseling appointments for a consumer based on the availability of required resources.	HD			
R3310	The system shall allow the integration of appointment scheduling with clinician maintained calendars.	HD			
R3311	The system shall permit appointment scheduling for: Individual, Group, Medication Support, Services to be Performed, and Unit of Time.	HD			
R3312	The system shall permit simultaneous appointment scheduling for multiple providers.	HD			
R3313	The system shall support the scheduling of recurring appointments according to user-defined frequency (e.g., weekly, biweekly, monthly).	HD			
R3314	The system shall permit over-booking groups.	HD			
R3315	The system shall permit double-booking consumers into a time slot for a clinician.	HD			
R3316	The system shall coordinate consumer schedules with a master schedule to avoid double booking consumers.	HD			
R3317	The system shall automatically alert staff when an appointment would result in a consumer being double-booked in multiple programs.	HD			
R3318	The system shall allow for the scheduling of group rooms.	HD			
R3319	The system shall permit authorized users to enter and maintain resource requirements for a scheduled appointment.	HD			
R3320	The system shall generate a notification to providers that includes a list of the resource requirements associated with a scheduled appointment.	HD			
R3321	The system shall permit Physicians to generate daily patient list that is integrated with and driven by patient appointments scheduled for a specific date.	HD			
R3322	The system shall allow an authorized user to add, delete, re-schedule, or cancel individual pending and booked appointments.	HD			
R3323	The system shall generate an appointment notification based on any schedule requirements associated with a physician order.	HD			
R3324	The system shall indicate the appointment type during scheduling activities.	HD			
R3325	The system shall indicate non-available appointment times based on the schedule of selected resources.	HD			
R3326	The system shall permit an authorized user to define appointment parameters based on insurance, program, or payor rules for individual and group services.	HD			
R3327	The system shall alert authorized users when conflicting appointments are entered.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3328	The system shall permit authorized users to view clinic schedules.	HD			
R3329	The system shall permit authorized users to view provider schedules.	HD			
R3330	The system shall permit authorized users to view consumer schedules.	HD			
R3331	The system shall permit authorized staff at one clinic to view the appointment schedule of a clinician at another clinic (e.g., if a patient calls the Vallejo clinic about their appointment at a Fairfield clinic).	HD			
R3332	The system shall maintain standard appointment disposition types (e.g., no-show, cancel, complete).	HD			
R3333	The system shall permit an authorized user to establish the priority of an appointment.	HD			
R3334	The system shall permit an authorized user to override the priority associated with a booked appointment.	HD			
R3335	The system shall maintain daily rosters of appointments.	HD			
R3336	The system shall generate an appointment list for current and future business day(s) by various parameters.	HD			
	The system shall export the appointment list to a file for future integration with call reminder systems.	HD			
R3337	The system shall generate appointment schedules for user-defined timeframes by: Clinic, Resource (e.g., staff, room), consumer.	HD			
R3339	In accordance with State regulations (Title IX), the system shall have the ability to print a paper copy of a consumer schedule of appointments that can be provided to the consumer.	HD			
R3340	The system shall generate a list of scheduled appointments a specified number of business days in advance that staff can use to call and confirm the appointment.	HD			
R3342	The system shall automatically generate, upon booking of an appointment, an card/notification letter containing instructions for the consumer to prepare for the appointment.	HD			
R3343	The system shall permit authorized users to customize the appointment notification letter, including editing and formatting changes.	HD			
R3344	The system shall generate notices of pre and post appointments in English and Spanish.	HD			
R3345	The system shall generate notices of pre and post appointments with consideration given to ensure that no confidential information is exposed.	HD			
R3346	The system shall initiate electronic call to remind consumer of upcoming appointments in English and Spanish, ensuring that no confidential information is exposed.	HD			
R3349	The system shall permit an authorized user to add, delete, re-schedule, or cancel group pending and booked appointments.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3350	The system shall support pending and booked appointment list management that allows an authorized user to add, delete, re-schedule, or cancel appointments at a clinic level.	HD			
R3351	The system shall generate a master appointment calendar showing a consumer appointments for other programs within the system.	HD			
R3352	The system shall permit staff to enter text notations and/or other pertinent information to convey to the consumer at the time the appointment is being scheduled.	HD			
R3353	The system shall indicate special requirements for a consumer prior to his/her appointment (e.g., if a consumer should be pre-medicated prior to the appointment, primary language, second language, hearing impaired, physically challenged).	HD			
R3354	The system shall associate any follow-up information with the original appointment.	HD			
R3355	For County-defined sensitive cases, the system shall hide appointments and entire case information from all but authorized staff (e.g., electronic sealing).	HD			
R3356	The system shall automatically remind staff when follow-up appointments for a consumer are needed.	HD			
R3358	The system shall capture confirmation of appointment status, including: Doctor/patient canceled, Patient no show, Appointment kept	HD			
R3359	The system shall track consumer attendance at group sessions, identifying consumers scheduled for group and failed to show, including the reason they failed to show.	HD			
R3360	The system shall report on the reason why a consumer or consumer(s) failed to show for group.	HD			
R2907	The system shall allow a consumer to be scheduled before they are a registered consumer such being assigned a "pre-consumer" before the initial visit.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.10 Wait List: The maintenance of a roster of consumers who have been deemed eligible for covered services, but cannot yet receive services due to provider or program capacity constraints. As active consumers complete or are removed from a program or service, individuals on the wait list are accepted into a program or service for treatment. Wait list management allows SCMH to maintain an accurate and up-to-date information on various program's capacity to provide different types of treatment to different types of clients, and how much of the capacity was utilized during specific time frames. Substance Abuse has some additional requirements imposed by the Department of Alcohol and Drug Programs' (ADP). Drug and Alcohol Treatment Access Report (DATAR) is the State system to collect data on Alcohol and Other Drug (AOD) treatment capacity and waiting lists. Solano County SA reports this information to ADP.					
R4346	The system shall maintain a roster of consumers who have been deemed eligible for covered services, but cannot yet receive services due to provider or program capacity constraints. As active consumers complete or are removed from a program or service, individuals on the wait list are accepted into a program or service for treatment	HD			
R3227	The system shall maintain information on a program's capacity to provide different types of treatment to different types of consumers and how much of the capacity was utilized during specific time frames.	HD			
R3228	The system shall permit authorized users to define and update the capacity for a given program as of an given date so that the capacity can be tracked and applied dynamically.	HD			
R3230	The system shall maintain a wait list of consumers who need to be scheduled in the next	HD			
R3231	The system shall capture, maintain, and store wait list parameters for a consumer (e.g., how long on, when taken off, etc.).	HD			
R3232	The system shall meet all State ADP Wait List and DATAR Reporting requirements.	HD			
R3234	The system shall order the wait list according to a user-defined acuity measure pulled from each consumer's assessment that determines each consumer's priority to receive	HD			

Functional Category Title	Section #	Description
Billing & Reimbursement	11.0	Provider Portal
	12.0	Payor/Program Management
	13.0	Coding
	14.0	Billing/Claims
	15.0	AR/Collections
	16.0	Electronic Transactions
	17.0	AP/Reimbursements (Managed Care)

How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/A for Not Applicable

Requirement		Prior.	How Met	Avail.	Comments
1.11 Provider Portal: Maintaining a website that offers a range of capabilities to County providers, both staff and contract, such as assess to client / staff schedules, client record and documentation, and professional credentialing and licensing information. A provider portal may support provider order entry and the viewing of associated results (i.e., labs). It could also support more efficient billing and reporting for County contracted business partners.					
R3523	The system shall enable the exchange of data with service providers (e.g., County contract providers, CBOs, other County agencies) to support care coordination for consumers and the capture of data needed for State-mandated reporting (i.e., CSI, CalOMS, DATAR).	HD			
R3524	The system shall support financial reporting with service providers.	HD			
R3525	The system shall support the sharing of outcomes data among authorized users	HD			
R3526	The system shall support online viewing of lab results for contract physicians, other contract service providers, and staff.	HD			
R3527	The system shall support online exchange of data with service providers for contract physicians, other contract service providers, and staff.	HD			
R3528	The system shall support online creation of service plans for contract physicians, other contract service providers, and staff.	HD			
R3529	The system shall support financial reporting with service providers for contract physicians, other contract service providers, and staff.	HD			
R3530	For Service providers and CBOs, the system shall permit: online entering and viewing CalOMS data	HD			
R3531	For Service providers and CBOs, the system shall permit: online sharing of outcome data	HD			
R3532	For Service providers and CBOs, the system shall permit: online submission of DATAR	HD			
R3533	For Service providers and CBOs, the system shall permit: online access to consumer record	HD			
R3534	For Service providers and CBOs, the system shall permit the online viewing of laboratory results.	HD			
R3535	For Service providers and CBOs, the system shall permit: online monthly billing and annual cost reports [need clarification]	HD			
R3537	The system shall permit the online creation of service plans by authorized clinicians for consumers on their caseload.	HD			
R3538	The system shall permit direct entry of CalOMS data by authorized users.	HD			
R3539	The system shall permit direct entry of DATAR data by authorized users.	HD			
R3540	The system shall permit direct entry of CSI data to the State by authorized users.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3542	The system shall permit authorized individuals (e.g., active consumers, clinicians, network providers, CBOs, etc.) to view lab test results.	HD			
R3543	The system shall allow a service provider and consumer to access a consumer's chart consistent with role and privacy and security considerations.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.12 Program/Payor Management: Organizing, entering and maintaining information on the program, payer, or guarantor that is responsible for the cost of a consumer's care. Information can include both data and business rules associated with the program (e.g., characteristics of target population, billing and rules, order of precedence to be established for billing services). A consumer may have one or more guarantors depending on the consumer, program, service, or source(s) of payment.					
R3910	The system shall be capable of capturing information on an unlimited number of Payers/Programs/Plans, including specific benefit or payment limits.	HD			
R3911	The system shall permit authorized staff to define, describe (e.g., narrative), and update a program/service/plan/payor without vendor support.	HD			
R3912	The system shall track and manage benefit limits, deductibles, co-pays, and covered and non-covered services for each plan.	HD			
R3913	The system shall capture and maintain details on multiple payors for a consumer.	HD			
R3914	The system shall support multiple fee schedules by payor with specific billing/adjust rules for each program and/or payor.	HD			
R3915	The system shall manage multiple reimbursement methods including fee for service, case rates, per diem, per minute, flat rate, capitation and grant-in-aid	HD			
R3916	The system shall assign and maintain a unique identifier for each program.	HD			
R3917	The system shall support per program fees.	HD			
R3918	The system shall support per session fees.	HD			
R3919	The system shall support drug testing fees.	HD			
R3920	The system shall support miscellaneous fees.	HD			
R3921	The system shall permit adjustments to consumer accounts at any point in the billing process by authorized users	HD			
R3922	The system shall capture, track and link services delivered to a Solano County consumer by out-of-network providers.	HD			
R3923	The system shall define, capture, and track information on any programs from which a consumer is receiving service. [Note: This can include: Adult Protective Services (APS), 26.5 California Childrens Services (CCS), Child Welfare Services (CWS), CalWORKS, Drug Court, ConRep, Mental Health Services Act, Probation, Substance Abuse Block Grant Funding, and other programs as may be specified by the County.]	HD			
R3924	The system shall track different funding sources, including: Short-Doyle Medi-Cal, Drug Medi-Cal, Medicare, Healthy Families, Funds from other counties, Insurance, Third Party Payors (e.g., victim witness), Grants, Private pay.	HD			
R3925	The system shall flag plan/program recipient services that are the responsibility of another county.	HD			
R3926	The system shall properly handle the sequential billing of payors (e.g. Medicare 1st, Private Insurance 2nd, Patient 3rd, and Medi-Cal 4th) ensuring that the sequence is based on both the coverage that the consumer has and the services that are covered by the various plans.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3927	The system shall maintain a consolidated master list of consumer insurance payors, organized by dates of coverage, and eligibility criteria.	HD			
R3929	The system shall accommodate complex billing rules that are specified by a County-defined structure based on program, clinician and clinic licensure, and funding source(s).	HD			
R3930	The system shall link consumer ID with what programs they are enrolled in, what payers they are eligible to be paid by, and the hierarchy of how the funding applies.	HD			
R3931	The system shall maintain current and historical rates for authorized services by program / provider in order to ensure payment of rate in force at time of service.	HD			
R3932	The system shall maintain and enforce current and historical billing rules by program/provider related to system-provided error checks on procedures and services (e.g., lockouts, cap on hours billed for service within a given program).	HD			
R3933	The system shall maintain a history of eligibility data for each payer and appropriately assign primary, secondary, and tertiary payers for services based on County-defined business rules.	HD			
	The system shall maintain historical rate tables.	HD			
R3934	The system shall allow the adjustment of information at any time, with changes effected in real-time (e.g., tracks retroactive adjustments for cases in which a consumer is added to a program with an effective date prior to the date of service).	HD			
R3935	The system shall permit the updating of the cascade level of insurance plans that have been changed for a consumer, and identify consumers who have lost their insurance coverage.	HD			
R4356	The system shall maintain the business rules which establish the sequence in which various payers can be billed for services rendered, associate funding to programs, and accommodates payer funding and source cascades.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.13 Coding: Selecting, documenting, maintaining and updating standard, industry-wide HIPAA compliant codes related to diagnoses (e.g., DSM-4TR, ICD-9) and procedures (e.g., CPT, HCPCS). Accurate and appropriate coding is essential to timely and optimal reimbursement for services rendered. Coding includes mapping proprietary vendor, County, and other program, payer, or plan codes to industry standard codes. Challenges facing SCMH in the near future include the transition to ICD-10 (mandated for use by CMS by October 1, 2013) and DSM-V (scheduled for release in May 2013).					
R3978	The system shall have system edits that support clinician selection of the proper diagnosis or code based on clinical judgment, including CPT, DSM, HCPCS, ICD, E&M codes. and County-defined codes that translate to standard code sets. (Note: See R3993 on crosswalk.)	HD			
R3979	The system shall enforce the selection of standard and appropriate service codes according to which services have been authorized for a consumer.	HD			
R3980	The system shall restrict service codes available to a provider to those services for which the provider is authorized to charge.	HD			
R3982	The system shall provide mapping / aggregating of individual codes to established DRGs.	HD			
R3983	The system shall ensure that provider documentation in the health record supports diagnosis and all billing-related codes included in claims, bills, or invoices.	HD			
R3984	The system shall maintain procedure codes and associated rates and be able to differentiate and maintain the procedure codes according to source/provider.	HD			
R3985	The system shall capture and retain current and past consumer diagnoses.	HD			
R3987	The system shall support the ICD-9-CM, International Classification of Diseases, standard code set.	HD			
R3988	The system shall support ICD-10 by October 1, 2013.	HD			
R3989	The system shall support the Current Procedure Terminology (CPT) standard code set.	HD			
R3990	The system shall support the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) standard code set.	HD			
R3991	The system shall maintain and update National Drug Codes (NDC).	HD			
R3992	The system shall allow County authorized users to maintain and update all reference tables and libraries without requiring direct vendor support (i.e., diagnosis codes, procedure codes, drug codes, rates, and related reference tables).	HD			
R3993	The system shall provide the ability to establish, maintain, and update crosswalks of one code set to another (e.g., DSM-IV and ICD-9-CM standard code sets) and to support translate between these code sets according to the established crosswalk..	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3994	The system shall automatically update standard code sets (e.g., ICD-9, ICD-10, CPT-4 and DSM-IV-TR) in order for system to always have the most recent code tables with effective dates to maintain history.	HD			
R3996	The system shall accommodate user-defined codes that are required at the local or State level (e.g., disallowance codes).	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.14 Billing/Claims and Consumer Statements: A billing statement represents a collection of charges for a specific consumer over a particular period of time. The billing process involves generating a claim document that documents and substantiates a request for payment of provided services. A billing statement can be generated via paper forms or electronically. A claim represents a request for payment for services/procedures that have been provided to a consumer. Services/procedures provided must be appropriate for the diagnosis in order to receive maximum allowed reimbursement. Claims may be submitted to institutional payers in paper or electronic format. A bill may be sent to the consumer for the balance due after claims to all other payer sources have been adjudicated. The County prepares and sends statements to consumers. There are at least three distinct revenue cycle management (RCM) streams in the SCMH which effect billing/claims and other financial processes: Short-Doyle billing/reimbursement for specialty mental health, FQHC-related billing for behavioral health (eventually including SA), and billing activities handled by Managed Care.					
R4000	The system shall capture various methods of consumer payment (e.g., via drop-down boxes).	HD			
R4001	The system shall assign a unique receipt number for each payment	HD			
R4002	The system shall support point-of-service check-out whereby charges are calculated and added to previous accounts receivable balances, payments are posted, and payment receipts are issued and printed.	HD			
R4003	The system shall permit the posting of payments to a consumer account even if there are no corresponding charges, and handles such payments as credit balances to be matched with charges at a later date.	HD			
R4004	The system shall capture billable services by linking back to rosters that document services received by virtue of a consumer attendance at group or individual counseling or treatment sessions.	HD			
R4005	The system shall capture all charges for unscheduled (Non-rostered) drug tests (e.g., outside lab charges and labor costs of County staff dedicated to lab testing).	HD			
R4006	The system shall recognize revenue, adjusted revenue, contractual allowances and sliding scale adjustments for each service from all sources at the time of entry based on the billing rules entered for insurance companies and self-pay consumers.	HD			
R4007	The system shall support charges recorded at standard fees and any contractual allowances or sliding scale discounts are recorded as adjustments to the standard fees.	HD			
R4009	Generating statements indicating services provided for a specified date range, including consumer name, payer name, programs, date/time/type of services rendered, date and amount of all deposits/payments received, outstanding balance, due date, etc.	HD			
R4010	The system shall calculate, bill and track consumer co-pays and deductibles.	HD			
R4011	The system shall calculate, bill and track consumer Share of Cost (SOC) Medi-Cal.	HD			

How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
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Requirement		Prior.	How Met	Avail.	Comments
R4012	The system shall calculate, bill and track the California Drug and Alcohol Program sliding scale requirements that include billing a pre-calculated monthly total, a pre-calculated per episode total, or per visit charges (depending on service type).	HD			
R4013	The system shall support other user-defined sliding scales, calculation of transfer in and out balances, and budget payment plans.	HD			
R4014	The system shall utilize retroactive enrollment data to produce Medi-Cal claims for services originally billed to other sources that are now Medi-Cal eligible, and make the proper adjustments to appropriate revenue, receivable and adjustment accounts.	HD			
R4015	The system shall permit retroactive Medi-Cal billing for up to 18 months after the original date of service.	HD			
R4016	The system shall produce user-defined, detailed consumer statements on demand.	HD			
R4017	The system shall produce user-defined detailed consumer statements on a cycle basis (e.g. every month).	HD			
R4018	The system shall permit an authorized user to disable the production of statements for a given consumer.	D			
R4019	The system shall be able to classify consumers into categories that control whether a statement is printed (e.g., all consumers under 100% of the federal poverty level are not sent statements).	HD			
R4020	The system shall permit reversal of charges on a bill (i.e., pulling out non-permitable charges).	HD			
R4021	The system shall generate a billing statement that reflects services provided, regardless of consumer account status or payment liability.	HD			
R4022	The system shall generate electronic or hardcopy bills for Medi-Cal consumers.	HD			
R4023	The system shall generate a bill for services with or without diagnosis code.	HD			
R4024	The system shall identify Medi-Cal retroactive eligibility and bill for covered services.	HD			
R4025	The system shall permit authorized staff to suppress bills or other materials from being printed or displayed according to user-defined parameters.	HD			
R4026	The system shall generate CMS 1500 bills.	HD			
R4027	The system shall generate UB04 bills.	HD			
R4028	The system shall generate Superbills.	HD			
R4029	The system shall support both real-time (i.e., DDE) and batch billing (i.e., claims) methods for any given consumer.	HD			
R4030	The system shall bill the right funding source for the right program (e.g., Growing Grounds program: if Conrep consumer, billed as Conrep; if not Conrep, not billable).	HD			
R4031	The system shall permit authorized staff to perform post-payment adjustments.	HD			
R4032	The system shall detect and prevent billing of low balance claims.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R4033	The system shall track each service provided, billed, and the amount paid, denied, or suspended at the consumer account level and by payor.	HD			
R4034	The system shall have the ability to print payer/consumer statements.	HD			
R4035	The system shall print or display a bill in chronological order for: Encounters	HD			
R4036	The system shall print or display a bill in chronological order for: Treatments	HD			
R4037	The system shall print or display a bill in chronological order for: Receipt number	HD			
R4038	The system shall print or display a bill in chronological order for: Date received	HD			
R4039	The system shall print or display a bill in chronological order for: Payor	HD			
R4041	The system shall print or display a bill in chronological order for: Adjustments and/or rate changes	HD			
R4042	The system shall print or display a bill in chronological order for: Share-of-cost adjustments	HD			
R4043	The system shall print or display a bill in chronological order for: Payments	HD			
R4044	The system shall print or display a bill in chronological order for: Billings	HD			
R4046	The system shall support the ability to bill third party payor sources.	HD			
R4047	The system shall support the authorization for payment to and reimbursement of third party payors.	HD			
R4048	The system shall produce paper claims for any service transaction both on-demand and in batch mode.	HD			
R4049	When Remittance Advices are posted, the system shall automatically transfer outstanding charges to secondary and tertiary payors and/or consumer responsibility, and produce the appropriate electronic and/or paper claim (forms).	HD			
R4050	The system shall automatically calculate payments due applying appropriate pre-determined contractual terms.	HD			
R4051	The system shall automatically compute and write-off the positive or negative contractual allowance amounts for bills, including capitated or grant-in-aid funding streams.	HD			
R4052	The system shall automatically bill or invoice per contract terms and conditions, and automatically make contractual adjustments (e.g., if $1200 for PHF day and contract with insurer is for $800, system bills insurance $800 and makes contractual adjustment of $400).	HD			
R4053	The system shall permit authorized staff to adjust claims and provide an audit trail for payment and charge adjustments.	HD			
R4054	The system shall perform automatic drug Medi-Cal billing with internal checks for group size, correct diagnosis, etc.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R4055	The system shall prohibit billing for services that were provided without prior authorization or approved treatment plans.	HD			
R4056	The system shall permit authorized staff to perform post-payment adjustments.	HD			
R4057	The system shall display and print payer invoices.	HD			
R4058	The system shall print or display a bill in chronological order for: Type of billing (Medicare, Medi-Cal, co-pay, private insurance, etc.)	HD			
R4121	The system shall provide the capability to establish a work queue for coding review prior to billing and/or claim submittal.	HD			
R4059	The system shall provide the capability to reconcile all payments received during a given date range. Reconciling by site/location, program. pay source type (e.g., cash, credit, money order, web, check), and payment for (e.g., program, testing, miscellaneous).	HD			
R4060	The system shall provide the ability to reconcile cash payments received against cash received posting log (i.e., for what service, how much, from whom, where received, and in what form of payment).	HD			
R3998	The system shall provide the capability for an authorized user to determine at the point of service, which program(s) a consumer is eligible for.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.15Accounts Recievable (AR)/Collections: Monitoring outstanding claims/bills, associating payments received with claims/bills issued, and following up on delinquent accounts.					
R4061	The system shall track on an ongoing basis deposits and payments received against programs/services rendered to a consumer and consumer liability and determine accounts and amounts due that are current, 30 days, 60 days, etc.	HD			
R4372	The system shall support the autoposting of receivables to a consumer's account.	HD			
R4062	The system shall support the generation of invoices for services provided.	HD			
R4063	The system shall determine the appropriate code/rate for invoice processing.	HD			
R4064	The system shall track data by invoice-processing information (e.g., Tax ID, Agency, Provider Name) and consumer identifier.	HD			
R4065	The system shall support the entry of point-of-service check-out whereby charges are calculated and added to previous accounts receivable balances, payments are posted, and payment receipts and account statements are issued.	HD			
R4066	The system shall reconcile the following against deposit receipts: consumer, payer source (e.g., Grants, Medi-Cal), date of service, billed amount, and paid amount.	HD			
R4067	The system shall permit adjustment of receivables for: Account adjustments, Therapeutic adjustments (waiver).	HD			
R4068	The system shall permit adjustment of receivables for: retroactive rate adjustments.	HD			
R4069	The system shall permit adjustment of receivables for: forgiven debt waiver (i.e., write-offs).	HD			
R4070	The system shall allow remaining balances to be released upon case closure and redirected to other sources.	HD			
R4071	The system shall print or display the transaction history for a specific consumer account, including all charges, payments, and adjustments for all payors for a specified date range.	HD			
R4072	The system shall print or display the transaction history for a group of consumer accounts, including all charges, payments, and adjustments for all payors for a specified date range.	HD			
R4073	The system shall print or display the transaction history for one or more specific payors, including all charges, payments, and adjustments for a specified date range.	HD			
R4074	The system shall print or display the transaction history of consumer responsibility, including all charges, payments, and adjustments for a specified date range.	HD			
R4075	The system shall print or display the transaction history for all payors, including all charges, payments, and adjustments for a specified date range.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R4077	The system shall notify clinicians/therapists when a consumer on their caseload has not had a face-to-face encounter in a specified number of days (e.g., 60 days).	HD			
R4078	The system shall notify clinicians/therapists when a consumer on their caseload has not made a payment in a specified number of days (e.g., 60 days).	HD			
R4080	The system shall allow a user to append notes captured during a collection call to the appropriate transaction and generate ticklers based on follow-up dates defined by the user.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.16 Electronic Transactions: Exchanging structured data, using agreed-upon HIPAA-compliant transaction code sets, from one entity to another (e.g., electronic claims submission). This is also considered to include exchanging electronic payment information, such as credit cards from clients or electronic fund transfers (EFT).					
R4082	The system shall comply with all HIPAA ASC X12N transaction set requirements.	HD			
R4083	The system shall be compliant with the ASC X12N 270/271 - Health Care Eligibility Benefit Inquiry and Information Response format.	HD			
R4084	The system shall be compliant with the ASC X12N 276/277 - Health Care Claim - Status Request and Response format.	HD			
R4085	The system shall be compliant with the ASC X12N 278 - Health Care Services Review - Request to Review and Response format.	HD			
R4086	The system shall be compliant with the ASC X12N 834 - Benefit Enrollment and Maintenance format.	HD			
R4087	The system shall be compliant with the ASC X12N 835 - Health Care Claim - Payment/Advice format -- for both send and revive.	HD			
R4088	The system shall be compliant with the ASC X12N 837P - Health Care Claim - Professional -- for both send and receive.	HD			
R4089	The system shall be compliant with the ASC X12N 837I - Health Care Claim - Institutional	HD			
R4090	The system shall maintain 835 and 837 formats that are properly matched to the California Department of Mental Health requirements.	HD			
R4091	The system shall maintain 835 and 837 formats that are properly matched to the California Alcohol and Drug Program requirements.	HD			
R4092	The system shall maintain 835 and 837 formats that are properly matched to the California Medi-Cal requirements.	HD			
R4093	The system shall maintain 835 and 837 formats that are properly matched to the California Drug Medi-Cal-specific requirements.	HD			
R4094	The system shall support standard encounter formats, either proprietary or industry-standard (837P).	HD			
R4095	The system shall comply with X12 Version 5010 counterparts to the 4010A1 Implementation Guides as currently mandated under HIPAA.	HD			
R4097	The system shall support electronic transfer of data to/from DMH ITWS for Short-Doyle Medi-Cal.	HD			
R4098	The system shall support electronic transfer of data to/from Targeted Case Management (TCM).	HD			
R4099	The system shall support electronic transfer of data to/from Medi-Cal Administrative Activities (MAA).	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R4100	The system shall support electronic transfer of data to/from third-party payors.	HD			
R4102	The system shall support electronic transfer of data to/from Healthy Families.	HD			
R4104	The system shall permit active consumers to make payments on their account using a personal credit card.	HD			
R4105	The system shall automatically assign a unique transaction number for every financial transaction in the system (e.g., to support audits).	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.17 AP/Reimbusement (Managed Care): Monitoring and making payments (e.g., reimbursement or compensation) due to providers for services rendered to consumers. Managed Care is responsible for AP/reimbursement for its contract provider under a FFS arrangement					
R4295	The system shall calculate or determine provider reimbursement based on contractual agreements, claims submission, and other requirements (e.g., utilization management and risk sharing).	HD			
R4296	The system shall permit authorized network providers to enter CMS 1500 claims directly into the system.	D			
R4297	The system shall accept scanned hard-copy paper claims (e.g., from billing companies used by certain network providers; from network providers who do not have e-mail).	D			
R4298	The system shall automatically compare a contractor invoice to contract terms and conditions (contract compliance) and notify staff of discrepancies.	D			
R4299	The system shall compare invoiced service units for a given period against services entered into the system by a contract provider and notify staff of discrepancies.	D			
R4300	The system shall screen Claims for proper eligibility including whether other insurance plans are primary.	D			
R4301	The system shall screen Claims for proper eligibility including the existence of an authorized provider.	HD			
R4302	The system shall screen Claims for proper eligibility including coverage for the specific service under the authorization.	D			
R4303	The system shall screen Claims for proper eligibility including service by an authorized provider.	D			
R4304	The system shall adjudicate claims on a per claim basis.	HD			
R4305	The system shall permit pending claims to be reviewed and denied if they do not have an appropriate authorization in the system.	HD			
R4306	The system shall track claims that have been entered, adjudicated, approved, and paid for the purpose of being able to reverse a claim.	HD			
R4308	The system shall automatically credit contractual allowances and other adjustments to accounts during payment posting based on pre-determined, carrier-specific criteria.	D			

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Requirement		Prior.	How Met	Avail.	Comments
R4309	The system shall report Denial notices to providers for specific reasons, including but not limited to: Claim is incomplete, consumer is not eligible, Provider is not eligible, Service dates do not match authorized dates, Service is not authorized, Diagnosis is not included in Scope of Benefits (specialty mental health carve-out), Retroactive coverage is not available, and Billing submittal is past the limitation period.	HD			
R4310	The system shall report on the activities and running balance of each account.	D			
R4311	The system shall help ensure that payment is provided on a timely basis.	HD			
R4312	The system shall generate a remittance advice by legal entity and/or by provider.	HD			
R4313	The system shall generate a remittance advice for each service paid that includes: Authorization Number, Service Date, consumer Name, Amount Paid, Share-of-Cost (if applicable), Claims Paid, Claims Denied and Reason, Claims Suspended and Reason, etc.	HD			
R4314	The system shall permit adjustments to the Remittance Advice for specific providers/facilities.	HD			
R4315	The system shall permit the user to choose whether to include or exclude Denials and Pended Claims from Remittance Advice reports.	D			
R4317	The system shall support coordination of benefits for Medi-Cal, Medicare, and other payors. (Note: COB/EOB coordination plus additional California Short-Doyle Medi-Cal process changes.)	D			
R4320	The system shall track claims and payments made to out-of-network providers (e.g., an out-of-network FFS psychiatrist who saw and billed for a Solano County patient receiving inpatient services outside of the County) and automatically generate EOBs.	D			
R4324	The system shall provide a comment field with access restricted to authorized accounting users (i.e., not part of the consumer record) for capturing text-based narrative, explanations, or comments related to accounts payable.	HD			
R4322	The system shall flag disallowed services using County and State reason codes at any stage in the billing process.	HD			

Functional Category Title	Section #	Description
Clinical Services / Documentation	18.0	Demographics Management
	19.0	ADT/Episode Management
	20.0	Health Record Management
	21.0	Assessments/Evaluations
	22.0	Treatment Plans
	23.0	Education/Counseling/Therapy
	24.0	Notes/Documentation

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	Requirement	Prior.	How Met	Avail.	Comments
1.18 Demographics Management: The initial collection, on-going updates due to correction or modification, and retention of current information that describes characteristics of individuals (e.g., consumers and providers) for the purpose of accurately and properly identifying individuals who provide, request and/or receive treatment and services. Data being captured on a client can include name, aliases, address, SSN, DOB, age, sex, race, primary language spoken, education, and other characteristics. Data being captured on a provider will also include licenses, credentials, a HIPAA-compliant National Provider Identifier (NPI).					
R3236	The system shall verify consumer status in a given program against the defined program outcome measures.	HD			
R3237	The system shall identify to an authorized user whether a consumer is on probation and if yes, capture probation Terms and Conditions and permit the user to view or print this information.	HD			
R3238	The system shall capture County-defined mandatory data for a consumer such as drivers license number, date of birth, and date of death.	HD			
R3239	The system shall flag and track Drug Court participants. (Substance Abuse)	D			
R3240	The system shall provide the ability to capture, maintain, update, and report on State-mandated California Alcohol and Drug Data System (CALOMS) demographic data.	HD			
R3241	The system shall provide the ability to capture, update, maintain, and report on State-mandated CSI demographic data.	HD			
R3242	The system shall track the number of services within program against annual estimated service number.	HD			
R3243	The system shall provide a summary screen, and generate a summary sheet (or face sheet), that contains key demographic information, administrative status (including Medi-Cal/insurance eligibility), pending appointments and dates of last service.	HD			
R3245	The system shall track cases by staff member assigned to a case.	HD			
R3246	The system shall verify the status (active/inactive) of a provider against information in the system regarding the provider contract and ability to deliver services to a consumer.	HD			
R3247	The system shall capture mandatory characteristics for all employee and contract clinicians: name, date of registration, location, discipline, licensure, specialties, and category (i.e., employee, contract, community-based program).	HD			
R3248	The system shall track practitioner status for eligibility or good standing in California; billing Medicaid and other payors, where applicable; and other practitioner data for all providers (both Network and County employed providers) that ensures clinicians and practitioners are duly licensed.	HD			
R3249	The system shall support the registering, tracking and reporting on provider organizations and individual clinicians that contract with the County.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3250	The system shall capture and track type of provider (e.g., Out-of-County, credentialed, organizational).	HD			
R3251	The system shall associate providers authorized to provide services under a given program with that program.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.19 Admission, Discharge, and Transfer (ADT)/Episode Management: ADT is the process of tracking a consumer's admission, discharge, and transfer (change in location), and often within an organization's health care system. ADT also keeps track of consumers who are placed on leave of absence but who remain active consumers. It includes transfers between settings, programs, or clinics; special population consumer status tracking. Episode management is maintaining single or multiple, simultaneous episodes/statuses for consumers who are receiving services on a concurrent or overlapping basis until the case is closed.					
R3368	The system shall allow a user to schedule, change, or remove an anticipated date that a consumer may present at a facility for inpatient services.	HD			
R3370	The system shall support the collection of data appropriate to a consumer's diagnosis, age, service setting, etc. as a consumer is admitted for service.	HD			
R3371	The system shall support a consumer's admission to an organizational provider through an admission order or form.	HD			
R3372	The system shall provide the capability for an authorized user to enter a consumer's advance directive and power of attorney into the electronic record upon admission.	HD			
R3374	The system shall provide the ability to set an alert to a designated staff member when a specific admission activity involving them is due.	HD			
R3377	The system shall track the release of patients after confirmation of discharge requirements.	HD			
R3378	The system shall support schedules organized by provider.	HD			
R3382	Acknowledges a change in patient status or location during an inpatient stay, e.g., transfers outside of the facility, but still within the same inpatient episode of care.	HD			
R3383	The system shall permit and track an authorized user to transfer an admission from one organizational provider to another.	HD			
R3385	The system shall capture data from and for other organizational providers.	HD			
R3386	The system shall maintain mandatory inpatient data: date of admission, referring provider, inpatient sponsor, outpatient authorization type, outpatient case manager, date of discharge, admit and discharge diagnosis, and legal status.	HD			
R3389	The system shall have the ability to define and track episodes of care for consumers based on State and local definitions of episodes	HD			
R3390	The system shall have the ability to track all of the care provided to an individual, by service or program, during a given time period (e.g., a consumer could have mental health and drug/alcohol episodes open at the same time and services would be tracked separately).	HD			
R3391	The system shall have the ability to track separate behavioral health episodes at the same time (e.g., tracking outpatient services and an admission to an inpatient facility during the same time period).	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3392	The system shall automatically flag episodes for closing if a user-defined, pre-determined period of no service has elapsed.	HD			
R3393	The system shall capture a consumer's requested guardianship and conservatorship.	HD			
R3395	The system shall track crisis episode data to include date and time of first contact, referral source, and clinical notes about the crisis.	HD			
R3396	The system shall provide user-defined checklists and text-based crisis notes that capture diagnosis, level of functioning, and other relevant clinical data.	HD			
R3397	The system shall track and permit easy viewing of the services provided during the crisis episode.	HD			
R3398	The system shall automatically alert the consumer case manager to track and monitor a crisis episode.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.20 Health Record Management: Health record management maintains the organization's legal health record in a way that is compliant with Federal, State, and local regulations and/or policies (e.g. HIPAA and 42CFR). Health record management involves recording, maintaining, retaining, and archiving consumer information to meet various functions, and ensuring the record is accurate, complete, and secure.					
R3412	The system shall assign and maintain for each consumer a unique identifier.	HD			
R3413	The system shall allow an authorized user to search and locate the record of a consumer in the MPI so that the correct person is identified before any actions are taken regarding that person.	HD			
R3414	The system shall support consumer look-up by one or multiple identifiers (e.g., name, alias, birth date, etc).	HD			
R3415	The system shall identify variations in name such as Middle Initial, AKA (also known as), Soundex (sounds like), or Variations relative to Driver's License Number.	HD			
R3417	The system shall rapidly retrieve the administrative status of any particular consumer (e.g., Medi-Cal/insurance eligibility, pending appointments and dates of last service).	HD			
R3418	The system shall automatically check for duplicate consumers.	HD			
R3419	The system shall automatically alert the user if there is a duplicate Family Number, consumer Number, consumer Name, Case Number.	HD			
R3420	The system shall prevent users from entering duplicate consumers.	HD			
R3421	The system shall permit authorized users to override warnings of duplicate consumers.	HD			
R3422	The system shall support photo ID with bar code capability.	HD			
R3423	The system shall store consumer number(s) for other programs, as needed.	HD			
R3424	The system shall store consumer number(s) for Managed Care Network.	HD			
R3425	The system shall store consumer number(s) for California Department of Social Services.	HD			
R3426	The system shall store consumer number(s) for California Department of Rehabilitation.	HD			
R3427	The system shall store consumer number(s) for Medi-Cal Eligibility Data System (MEDS).	HD			
R3430	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print a unique Master consumer Record.	HD			
R3432	The system shall permit authorized users to merge consumer records.	HD			
R3433	The system shall require user confirmation prior to merging any consumer demographic information.	HD			
R3434	When merging duplicate records, the system shall merge information associated with the incorrect consumer identifier(s) with the correct record and consumer identifier.	HD			
R3435	When merging records, the correct consumer identifier(s) shall be retained and the incorrect consumer identifier(s) will be retained as void.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3436	The system shall be able to create separate records from consumer records erroneously merged.	HD			
R3437	The system shall retain the history of all prior Addresses, Multiple Phone numbers, Multiple e-mail addresses, Photos, Eligibility Statuses, AKAs (also known as), Record Numbers	HD			
R3438	The system shall maintain an historical audit trail on record of all changes, such as additions and deletions, by user.	HD			
R3439	The system shall have consumer data purging and archiving capability with the flexibility to set variable time parameters and limits.	HD			
R3440	The system shall support electronic retrieval of records from archive.	HD			
R3441	The system shall flag a sensitive or confidential consumer case.	HD			
R3442	The system shall meet co-occurring disorders (dual diagnosis) data access requirements.	HD			
R3443	The system shall permit configurable Clinical history screens.	HD			
R3444	The system shall electronically restrict access to and secure all consumer records.	HD			
R3445	The system shall maintain all history of past diagnoses, treatment plans, services, and medications as well as consents, release of information, and so forth.	HD			
R3446	The system shall utilize the unique consumer identifier to mange consumer records.	HD			
R3447	The system shall automatically date and time stamps all entries in the consumer record.	HD			
R3448	The system shall provide the capability for authorized users to customize templates for medical reports.	HD			
R3449	The system shall have the capability to capture, retain, retrieve, and update a consumer's legal representative as part of the consumer record.	HD			
R3450	The system shall generate a summary of a consumer's current demographic, financial, insurance, and clinical data (Face Sheet) as defined by County.	HD			
R3451	The system shall provide the capability for authorized users to enter a diagnosis and effective dates, to include primary, secondary, and tertiary diagnoses for AXIS I through V.	HD			
R3452	The system shall generate a notification to licensed providers to co-sign documentation prepared by unlicensed providers (e.g., students).	HD			
R3453	The system shall support the use of established templates to configure the electronic consumer Record according to the clinical care being provided.	HD			
R3454	The system shall provide the capability for an authorized user to configure the structure and fields within the electronic consumer record within parameters provided by the system vendor.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3455	The system shall provide the capability for an authorized user to determine the attributes that govern the valid values to be used within the electronic consumer record.	HD			
R3456	The system shall provide the capability for an authorized user to determine how the electronic consumer record is organized and formatted for viewing and reporting.	HD			
R3457	The system shall provide the capability for authorized users to determine the access privileges by role for each section in the electronic consumer record to meet privacy and security requirements.	HD			
R3458	The system shall provide the capability for an authorized user to enter charges related to services entered in consumer record.	HD			
R3459	The system shall allow County to define the business rules as to which entries in the Consumer/Patient record require an electronic signature for approval, who must provide the approval, and when the approval is needed.	HD			
R3460	The system shall provide the capability for an authorized user to access any part of the consumer history according to their system-defined role.	HD			
R3461	The system shall generate a chronological, diagnosis-driven problem list.	HD			
R3462	The system shall restrict access to and update of a diagnosis-driven chronological problem list by system-defined user role.	HD			
R3463	The system shall support the incorporation of checklist and/or health maintenance reminders for clinicians based on consumer diagnosis.	HD			
R3464	The system shall provide the capability to define and automate workflows that involve any documentation associated with the consumer record to include: Routing rules, Due dates for completion and/or approvals, and Notifications and alerts regarding past or future due dates.	HD			
R3465	The system shall provide an audit trail of users accessing and using electronic and physical consumer records.	HD			
R3466	The system shall provide a means to track consumer authorization by each specific type of Release of Information.	HD			
R3467	The system shall maintain the user name, location, date, and time, based on HIPAA privacy and security requirements, when a user duplicates any part of the electronic or physical consumer record for any media.	HD			
R3468	The system shall generate and send notifications to users of any limited information disclosure request or requirement as specified in the electronic consumer record.	HD			
R3469	The system shall generate a notification to users attempting to use sections of consumer records currently open for update by another user.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3470	The system shall generate reminders to appropriate County staff regarding completion and/or resolution of documentation in the consumer record to meet compliance requirements.	HD			
R3473	The system shall track and report on all unsigned/co-signed reports, results, etc.	HD			
R3475	The system shall support electronic signature for signing of clinical and/or legal documentation that is part of the consumer record.	HD			
R3476	The system shall support tasks and work flow associated with supervision of interns (e.g., required approval or co-signature of an intern's note before it can be billed).	HD			
R3477	Ensuring consumers, staff, and external sources have access to or receive needed personal health information (PHI) in a manner consistent with HIPAA and other pertinent business requirements.	HD			
R3478	The system shall generate, maintain, and monitor various Release of Information forms.	HD			
R3479	The system shall maintain and store signed release of information forms.	HD			
R3480	The system shall enable users to select standard release forms.	HD			
R3481	The system shall capture the following disclosure information: Date of disclosure, To Whom the information was disclosed, Reason for disclosure, Information disclosed, and Person releasing the information.	HD			
R3482	The system shall track all disclosures of information.	HD			
R3483	The system shall provide the capability to de-identify/redact data reported and released according to County Privacy Policy.	HD			
R3484	The system shall provide the capability to define, document, manage, and track in the electronic record: All requests for Release of Information, Authorizations, Revocations, Consents	HD			
R3485	The system shall track the status of each Request for Information as received, pending, denied, or completed.	HD			
R3486	The system shall mark all released information with the appropriate County standard disclosure clause for a specific type of release of information.	HD			
R3487	The system shall mark all released information as not available for further disclosure unless consumer authorization is provided.	HD			
R3488	The system shall support the implementation of specific rules regarding Release of Information policies, procedures, and protocols to include: the creation of forms appropriate to the type of Request, defining user roles who are permitted to release information, and defining necessary correspondence related to a type of Release.	HD			
R3489	The system shall generate an invoice for any associated fees triggered by a specific type of Request for Information.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3490	The system shall generate any necessary correspondence related to a Release of Information.	HD			
R3491	The system shall provide an audit trail (i.e., disclosure log) on any information related to the release or disclosure of consumer information.	HD			
R3492	Ensuring accurate, current, and necessary consents and authorizations are completed, stored, and accessible to providers; includes tracking disclosures, directives, etc.	HD			
R3493	The system shall generate, maintain, and monitor various Consent and Authorization forms.	HD			
R3494	The system shall generate, maintain, and monitor various Advanced Directives, Durable Power of Attorney forms, etc.	HD			
R3495	The system shall maintain and store signed consent and authorization forms, Advanced Directives, DPAs, etc.	HD			
R3496	The system shall capture and retain current and historical dosage range for inpatient medications directly on the consent or authorization form.	HD			
R3498	The system shall support speech/voice recognition, dictation, transcription, and text-to-speech.	HD			
R3499	The system shall support the electronic export/import of dictation/transcription of all notes.	HD			
R3501	The system shall have the capability to capture/import and store an external file, associate it (i.e., image, document, audio) with any record or its associated metadata in the system (i.e., consumer record), and manage (i.e., index. print, annotate,) the file in an compatible Agency-standard format.	HD			
R3502	The system shall support the display, management, and annotation of standard image formats (e.g., TIFF, JPEG, GIF, BMP, PNG)	HD			
R3503	The system shall support the capability for voice to text on voice files and to manage the output together with the audio clip.	HD			
R3504	The system shall assign a unique identifier to each image (or other file) being referenced by the system.	HD			
R3505	The system shall have the capability for performing optical character recognition (OCR) on image in County standard formats and to manage the resulting output together with the original image.	HD			
R3506	The system shall be extensible to incorporate the display and management of other electronic file formats described by a formal standard or vendor specification.	HD			
R3507	The system shall provide the capability for an authorized user the ability to annotate a file electronically and save the annotation with the file.	HD			

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	Requirement	Prior.	How Met	Avail.	Comments
1.21 Screenings/Assessments/Evaluations: Screenings, assessments, and evaluations are tools used by service providers to determine the current condition (e.g., psychological, psychiatric, medical, emotional, severity of abuse) of a consumer across a variety of parameters for the purpose of deciding appropriate intervention, treatment, and follow-up. Review eligibility for appropriate program(s) or service(s). Assessments and evaluations provide information on persons who likely or definitively have a mental health problem and/or substance abuse problem. Assessments and evaluations may be periodically re-administered to ensure that clinicians have up-to-date information on a consumer's current mental health status. Documentation of medical history, physical exams findings, and vital signs may be included as part of the screening/assessment/evaluation.				
R3550	The system shall provide a variety of pre-defined assessment forms including, psycho-social assessments, intake assessments, inpatient evaluations, and client/patient placement evaluations.	HD			
R3551	The system shall ensure that data captured during previous non-clinical consumer contacts (e.g. demographic data, address, current diagnosis) are automatically populated in assessments.	HD			
R3552	The system shall permit methods to directly capture crisis information so that crisis info is immediately available during the County's intake assessment process.	HD			
R3553	The system shall provide a link and integration of CalOMS to the system database.	HD			
R3554	The system shall automatically calculate a consumer's SASSI score from previously entered data.	D			
R3555	The system shall support the ASI Lite with standard levels of care per the American Society of Addiction Medicine (ASAM).	D			
R4365	The system shall support the LOCUS© and CALOCUS© assessment tools.	HD			
R3556	The system shall grant users the option to create a mental status exam using a previously completed exam as a template.	HD			
R3558	The system shall flag assessments that are incomplete due to consumer behavior.	HD			
R3559	The system shall automatically flag consumers at high-risk for suicide/homicide/sex offender/assaultiveness based on user-defined criteria.	HD			
R3560	The system shall restrict access to the record for specific consumer populations (e.g., registered sex offenders, HIV, consumers in substance abuse programs).	HD			
R3561	The system shall support the periodic tracking of patients by location according to user-defined frequency (e.g. every 5 minutes).	HD			
R3562	The system shall support Safety related to seclusions and restraints.	HD			
R3563	The system shall permit the creation of a variety of critical incident types that can be easily entered and retrieved.	HD			
R3564	The system shall support user-defined policies that determine procedures and responsibilities for following-up all incident types.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3565	The system shall provide user-defined, configurable alerts that support incident tracking.	HD			
R3566	The system shall maintain a priority list or &"Hot List"; of at-risk consumers that can be accessed electronically by staff at all times.	HD			
R3567	The system shall support gathering a comprehensive health history and current health concerns if needed.	HD			
R3568	The system shall capture the recording of patient vital signs.	HD			
R3569	The system shall support the assessment of a consumer's developmental history.	HD			
R3570	The system shall maintain History & Physical assessment data for a consumer.	HD			
R3571	The system shall permit authorized users to view and report on consumer-related health parameters over time as part of H&P history.	HD			
R3572	The system shall support the graphical trending of information within the health and physical part of the consumer record to include vital signs.	HD			
R3574	The system shall support user-defined nursing assessments.	HD			
R3579	The system shall offer a forms development tool set that supports the creation of user-defined assessment forms.	HD			
R3580	The system shall allow for optional 3rd party licensed assessment tools to be incorporated into the system.	HD			
R3581	The assessment function shall be configurable to generate targeted problems for treatment and such problems can flow to the treatment planning process.	HD			
R3582	The system shall have a standard template for assessment which can be tailored to consumer needs and specific programs.	HD			
R3583	The system shall trigger prompts for portions of assessments that need continual monitoring (e.g., progress notes)	HD			
R3584	The system shall support collection of mandatory (required) data (e.g., clinician can't leave section blank, must indicate why information is not available.)	HD			
R3585	The system shall ensure all ancillary documentation is completed before the assessment is deemed complete.	HD			
R3586	The system shall support role-based access and authorities ensuring appropriateness of staff (e.g., ensure licensure is correct).	HD			
R3587	The system shall support the capability to declare a version (designated by section) as final (i.e., official) and prohibit further change to that version.	HD			
R3588	The system shall maintain multiple historical iterations of assessments.	HD			
R3589	The system shall permit an authorized user to access the appropriate assessment tool/template based on the care being provided for a consumer.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3590	The system shall permit an authorized user to complete the assessment according to the rules associated with that assessment.	HD			
R3591	The system shall permit an authorized user to access and view assessment data.	HD			
R3592	The system shall permit an authorized user to review a completed assessment.	HD			
R3593	The system shall permit an authorized user to update (append to) the assessment as needed.	HD			
R3594	The system shall permit an authorized user to electronically sign the completed assessment, if required.	HD			
R3595	The system shall pre-populate data from other sources or previous assessments into the current assessment to reduce double data entry.	HD			
R3596	The system shall maintain completed assessments in the clinical section of the consumer record.	HD			
R3597	The system shall provide the capability for authorized users to develop, manage, and implement standard and custom assessment templates and result formats.	HD			
R3598	The system shall allow support the ability to create user-defined reports based on consumer-related health parameters	HD			
R3599	The system shall provide the capability for authorized users to access and view the status of periodically required screening, evaluations, and/or assessments.	HD			
R3600	The system shall support electronic versions of the assessments used by the County.	HD			
R3601	The system shall generate notifications to a clinician when an assessment is due based on workflow and documentation requirements for that type of assessment.	HD			
R3602	The system shall send notifications to members of a consumer's care team when inconsistencies in assessment results are reported.	HD			
R3603	The system shall provide the capability for authorized users to schedule periodically required screening, evaluations, and/or assessments	HD			

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	Requirement	Prior.	How Met	Avail.	Comments
1.22 Treatment Plans: Preparing and documenting a multi-disciplinary approach to addressing a consumer's problems, condition and needs for the purpose of restoring the individual to health. Treatment plans vary by program and are based on assessments and evaluations conducted by multiple disciplines, often with consumer and/or family input during treatment team meetings. Treatment plans provide documentation often required by payers to substantiate claims submitted for reimbursement of covered services. Treatment plans are re-evaluated per program guidelines. Note: SCMH is participating in the current CIMH project to develop a standardized treatment plan for California counties.					
R3576	The system shall automatically populate the care plan from the interim treatment recommendations.	HD			
R3605	The system shall automatically populate the Initial treatment plan and subsequent treatment plan reviews from CalOMS, CSI, and other assessment instruments	HD			
R3607	The system shall provide a template to aid the consumer and their case manager in the development of a Crisis Management Plan.	HD			
R3608	The system shall track and report crisis episode data including date and time of first contact, referral source, clinical notes about the crisis including checklists and text-based crisis notes that allow for the easy recording of diagnosis, level of functioning, and all relevant clinical data.	HD			
R3609	The system shall alert the case manager (referral source) and appropriate clinician that a crisis contact has occurred.	HD			
R3610	The system shall permit authorized consumers and providers secure access to view the services provided during the crisis episode.	HD			
R3612	The system shall provide a care plan that captures diagnosis codes, notes, assessment information, service types, reporting units, authorization information, and staff signatures.	HD			
R3613	The system shall permit Interim treatment recommendations that were automatically brought forward to be edited or deleted.	HD			
R3614	The system shall provide the capability for an authorized user to define a care plan, documenting problems identified, goals established, and care plan tasks required	HD			
R3615	The system shall provide the capability for an authorized user to update the care plan, including problems, goals, and required care plan tasks	HD			
R3616	The system shall provide the capability for an authorized user to record completion of care plan tasks, including protocols, orders, and interventions completed and follow-up and evaluation activities performed for a consumer	HD			
R3617	The system shall provide the capability for an authorized user to document outcomes.	HD			
R3618	The system shall support the templates that can be used to create reusable care plans based on protocols, standing orders, or common interventions.	HD			
R3619	The system shall allow simultaneous review of care plans by multiple authorized users.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3620	The system shall provide the capability for authorized users to maintain a list of goals for a consumer care needs.	HD			
R3621	The system shall provide the capability for authorized users to maintain an interdisciplinary problem list.	HD			
R3622	The system shall generate notifications to clinicians when care plan updates are required according to the documentation rules established for that care plan.	HD			
R3623	The system shall provide the capability for an authorized user to create user-defined fields and/or free text in the care plan.	HD			
R3624	The system shall provide the capability for an authorized user to create and manage standardized inter-disciplinary problem lists.	HD			
R3625	The system shall support practice guidelines and evidence-based medical practices that provides an alert to a user resulting from a response to an assessment query.	HD			
R3626	The system shall have the capability to provide suggestions for updates and revisions to a care plan based on problems identified in recent clinical assessments based on best practice guidelines and evidence-based medical practices.	HD			
R3627	The system shall maintain an intervention list based on rules defined in the system for best practice guidelines and evidence-based medical practices.	HD			
R3628	The system shall provide the capability for authorized users to re-activate a plan of care for a discharged consumer who is re-admitted to the County system (e.g., returns from an outside facility).	HD			
R3629	The system shall provide the capability for authorized users to re-activate a plan of care for a consumer who is transferred within the County system.	HD			
R3630	The system shall provide the capability for authorized users to access and incorporate external communication and health education materials that correlate with a consumer care plan.	HD			
R3631	The system shall print suggested communication and health education materials that correlate with a consumer care plan.	HD			
R3632	The system shall generate and send a notification to physicians to when a consumer treatment plan is to be certified.	HD			
R3633	The system shall provide the capability for an authorized user (e.g., nurse) to view the current list of care plan problems.	HD			
R3634	The system shall provide a Master Service Plan that captures at least three objectives for each service type on the Care Plan.	HD			
R3637	The system shall populate the treatment plan from target areas in the assessment, all field are updateable by the user.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3638	The system shall permit some data from the treatment plan to automatically populate the case/contact note.	HD			
R3639	The system shall prohibit clinicians from entering notes without an approved treatment plan.	HD			
R3640	The system shall alert the case manager when a new treatment plan is due according to a user-defined time period (e.g., 30, 40, 60 or 90 days), and with the ability to defer (or snooze) until complete.	HD			
R3641	The system shall permit authorized staff at Community-Based Organizations to view treatment plan due dates for specific consumers.	HD			
R3642	The system shall permit clinicians to build treatment plans for multiple target populations using a clinical database of best practice guidelines that move clinicians through the diagnoses, problem, goals, objectives and interventions.	HD			
R3643	The system shall provide a Master Service Plan that captures time frames and metrics (measurable) for each objective on each service type on the Care Plan.	HD			
R3644	The system shall electronically route and authorize treatment/plan/service with notification to appropriate staff.	HD			
R3646	The system shall capture additional services with goals, interventions, and outcomes as needs are identified.	HD			
R3647	The system shall print pertinent information on forms and reports (e.g., Unified Service Plan, assessments).	HD			
R3651	The system shall automatically create a discharge summary using as much information as possible from information previously captured (e.g., admission diagnosis from the face sheet, mental status exam from initial evaluation, discharge meds, etc.).	HD			
R3653	The system shall generate the California Treatment Authorization Request (TAR).	HD			
R3654	The system shall provide industry standard clinical libraries of best practice information on treatment interventions for inquiry by clinicians.	HD			
R3655	The system shall make available clinical best practice information available for inquiry at any time during the clinical decision-making process (e.g., when entering progress notes, during treatment planning, and prescribing).	HD			
R3656	The system shall permit authorized users to create, edit, and delete elements of the clinical best practice guidelines.	HD			
R3657	The system shall maintain an interface to multiple best practice libraries.	HD			
R3658	The system shall maintain treatment plan templates that contain structure and standard content. The system shall allow these templates to be modified as needed by an authorized user.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3659	The system shall permit the creation of user-defined treatment plan data fields.	HD			
R3660	The system shall record and track multiple treatment and discharge plans for a single consumer at one time, and consolidate information into a single report.	HD			
R3661	The system shall allow for the development of structured planning formats as well as the entry of free-form text.	HD			
R3662	The system shall support the use of clinical rule-bases for aiding in the development of treatment plans that are consistent with clinical best practices.	HD			
R3663	The system shall maintain an updated consumer service / treatment plan readily accessible to defined users, that capture thresholds of consumer adherence through feedback loops and automated alert capabilities.	HD			
R3664	The system shall allow for periodic updates to the existing treatment plan as consumer needs arise.	HD			
R3665	The system shall permit simultaneous viewing of multiple treatment plans on a single consumer.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.23 Education/Counseling/Therapy: Education, counseling, therapy, and medication are common approaches to treatment of mental health problems. The processes by which these services are provided are core components of a consumer's treatment and are provided in accordance with the treatment plan. Documentation of units of service is required by funding sources and payers.					
R3667	The system shall maintain a record of current curriculum components for educational activities.	HD			
R3669	The system shall capture and alert authorized users when consumer/therapist ratio exceeds user-defined program standards.	D			
R3670	The system shall display all group members that are registered and active in the system when services are entered for a group to allow rapid data entry.	HD			
R3671	The system shall notify the clinician when a consumer's treatment or program requirements are not being or have not been met.	HD			
R3672	The system shall separately capture therapist and co-therapist time.	HD			
R3673	The system shall automatically perform error checks to verify accuracy of data entered and reduce therapist billing errors.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.24 Notes & Documentation: Notes and documentation refers to entering information into a consumer's record. Notes and documentation are required to record service, treatment, or care-related comments and findings that may be related to assessments, evaluations, history, physicals, lab results, reaction to medications, special diets, etc. Notes needs to address the preparation of documentation for both individual and group sessions.					
R3692	The system shall support multiple note types needed to document the various activities required to manage consumer placement cases.	HD			
R3693	The system shall permit user customization of progress note types, formats, and content according to the requirements of each program.	HD			
R3694	The system shall provide the ability to modify the case notes template by the type of service.	HD			
R3695	The system shall progressively remind users to enter notes within a County-defined time period from the date of service according to business rules for note completion.	HD			
R3696	The system shall support progress notes for individuals and for groups.	HD			
R3697	The system shall support supplemental notes.	HD			
R3698	The system shall integrate hand-written notes into the record (e.g., able to scan and apply intelligent character recognition).	HD			
R3699	The system shall include standard word processing functions with spell check to compose notes.	HD			
R3700	The system shall support field workers (to include Crisis Mobile) sending real-time data or uploading data to central system daily when computer is docked (Note: Does not denote wireless)	HD			
R3701	The system shall have free-text fields that accommodate lengthy entries.	HD			
R3703	The system shall provide the capability for authorized users to enter electronic progress notes and recommendations.	HD			
R3704	The system shall restrict user access to sections of a progress note according to user role.	HD			
R3705	The system shall permit clinicians to view the current treatment plan while writing a progress note.	HD			
R3707	The system shall permit access to both inpatient and outpatient notes within a single consumer record simultaneously.	HD			
R3708	The system shall support importing inpatient unit (i.e., PHF) notes into the consumer record with appropriate edits.	HD			
R3709	The system shall link progress notes to the treatment plan as required by regulatory guidelines.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3710	The system shall have the option to prohibit clinicians from entering notes without an approved treatment plan.	HD			
R3711	The system shall flag the need to complete the progress note for individual participation in a group session.	HD			
R3712	The system shall automatically populate individual notes with Group note information (that details the group content / structure) for each individual in the group.	HD			
R3713	The system shall permit the annotation of an individual group note to describe how each person responded to that content.	HD			
R3714	The system shall enable Group notes to be set up so that the entire group can be opened at one time, ensure consistent documentation across the group, and make sure that individualized information can be entered.	HD			
R3715	The system shall support linking a consumer's notes to other information, either maintained in the system or in other County systems, the linkage related to the consumer's family as defined by program requirements.	HD			
R3716	The system shall ensure that notes are automatically populated with information previously captured (e.g., patient demographics, RU, time, diagnosis, and mental status exam).	HD			
R3717	The medication entered in the prescribe today field on the progress note automatically populates the prescription, medication consent, and medication log.	HD			
R3718	The system shall provide the capability for a progress note to be organized by discipline.	HD			
R3720	The system shall provide the capability for authorized users to view and print progress notes in chronological order.	HD			
R3721	The system shall generate notifications to designated recipients when time-specific progress notes/documentation is required according to documentation rules established for progress notes.	HD			
R3723	The system shall provide the capability for authorized users to maintain daily and weekly discharge information.	HD			
R3724	The system shall automatically generate a service transaction which is linked to an approved progress note.	HD			
R3725	The system shall not forward a service transaction to the billing until the progress note is final (i.e., not pending).	HD			
R3726	The system shall be configurable so the automatic generation of the service transaction may be disabled and the process completed manually. This may be required for particular organizational providers or clinical staff.	HD			

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How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/A for Not Applicable

Requirement		Prior.	How Met	Avail.	Comments
R3727	The system shall immediately validate all services entered into the system.	HD			
R3728	The system shall automatically validate that services rendered were performed by appropriately credentialed staff.	HD			
R3729	The system shall maintain the note history by program, site, and admission episode.	HD			
R3730	The system shall integrate attendance records for scheduled sessions with consumer notes.	HD			
R3732	The system shall support a protocol-driven order process that is based on best clinical practice.	HD			
R3733	The system shall support the design and implementation of standard workflow processes for order entry that consist of one or more steps, establishes the time periods for each step in the workflow process, defines approval process (including the specific parameters needed for approvals and the approving user/role needed at each specific step), and enforces the approval process through the use of electronic signatures.	HD			
R3734	The system shall associate the ordering provider and the attending physician with a single order.	HD			
R3735	The system shall provide the capability for additional, multiple providers and/or clinicians to be associated with a single order, such as members of the consumer care team.	HD			
R3736	The system shall provide the capability for an authorized user to define a series of orders or recurring orders to be entered once with multiple dates in the future.	HD			
R3737	The system shall support best clinical practice/protocol-driven order sets (e.g., bundled lab orders per MD-ordered withdrawal protocol).	HD			
R3738	The system shall provide the capability to create order sets, save standard orders sets for re-use, update order sets, and tag order sets as inactive or not in use.	HD			
R3739	The system shall support standing orders.	HD			
R3740	The system shall allow an authorized user to mark an order as no charge during entry or update.	HD			
R3741	The system shall provide a user interface for an authorized user to enter an order online, via voice recognition, and via transcription of a hand-written or verbal order.	HD			
R3742	The system shall route the order to the appropriate recipient(s) as defined by the clinical workflow.	HD			
R3743	The system shall transmit the order to a designated recipient using routing methods internal to the system (i.e., workflow), e-mail, and FAX	HD			
R3744	The system shall transmit the order to external providers by FAX, electronic interface with other systems (e.g., HL7), secure email, on-line access by external provider.	HD			

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Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/A for Not Applicable

Requirement		Prior.	How Met	Avail.	Comments
R3745	The system shall provide the capability for a user to enter directly into the system (i.e., consumer record) at the point of care/service the treatment, services, and/or and supplies being provided.	HD			
R3746	The system shall automatically generate all appropriate forms (e.g., consent form) and navigate to appropriate screens according to the order or protocol.	HD			
R3747	The system shall flag contraindications when a medication is ordered, including allergies, food-drug, or drug-drug interactions.	HD			
R3748	The system shall generate an alert when a medication ordered exceeds the dosage range.	HD			
R3749	The system shall generate a medication consent form when specific medications are ordered by an inpatient provider (e.g., Benzodiazepines, hypnotics, narcotics, neuroleptics, mood stabilizers, and other medications that alter a persons sensorium).	HD			
R3750	The system shall generate a medication consent form when any medication is initially ordered.	HD			
R3751	The system shall permit inpatient providers to adjust medications without generating or requiring a new consent or authorization form.	HD			
R3752	The system shall generate a medication consent form when an outpatient mental health service provider changes the dosage range for a medication already ordered.	HD			
R3753	The system shall support medication-specific, protocol-based triggers for inpatient lab orders and clinic-based lab work.	HD			
R3754	The system shall provide alerts relative to time limits or expirations of orders (e.g., medications, lab results).	HD			
R3755	The system shall provide an electronic MAR that is automatically updated by orders, and is integrated with the record.	D			
R3756	The system shall automatically transfer the order to the MAR and to the pharmacy system.	D			
R3757	The system shall provide a universal medication profile for a consumer that ensures medication orders, medications dispensed, and medication administration records adhere to protocols associated with the medication profile.	HD			
R3758	The system shall provide a universal medication profile for a consumer that ensures standing orders and order sets for tests (e.g., lab) are appropriate.	HD			
R3759	The system shall match a consumer drug test profile to a consumer drug of choice to ensure that appropriate tests are ordered based on medications reported by consumer.	HD			
R3760	The system shall provide alerts and notifications based on due dates (e.g., labs are overdue) and protocols (e.g., medication protocols require recurring lab, seclusion and restraint protocols).	HD			

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How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
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Requirement		Prior.	How Met	Avail.	Comments
R3148	The system shall allow a clinical document to be saved but not completed, completed, signed and finalized.	HD			
R4366	The system shall allow information to be appended to finalized clinical documents can be appended with a new, separate signature.	HD			
R4367	The system shall date, time, and user stamp all steps in the clinical documentation	HD			
R4368	The system shall not allow documentation that has been electronically signed to be modified in keeping with medical record standards.	HD			

Functional Category Title	Section #	Description
Coordination of Care	25.0	IEP
	5.0	Referrals
	26.0	Case Management
	27.0	Community Education & Outreach

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How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/A for Not Applicable

Requirement		Prior.	How Met	Avail.	Comments
1.25 Individualized Education Plan (IEP): Each public school child who receives special education and related services must have an Individualized Education Program (IEP). Upon referral by a school, SCMH IEP staff provides an assessment and generates a 26.5 Report. School and SCMH staff meet to review, approve, and develop treatment goals and objectives. The Individuals with Disabilities Education Act (IDEA) requires certain information to be included in each child's IEP. Local school districts include additional information in IEPs in order to document that they have met certain aspects of federal or state law which results in IEP forms looking different from school system to school system.					
R3676	The system shall provide the school with portal access to initiate an IEP referral.	HD			
R3677	The system shall identify consumers that receive IEP-driven (and billable) services and verify consumer age meets requirements for AB3632 services.	HD			
R3679	The system shall alert/notify appropriate staff when the next IEP is due.	HD			
R3680	The system shall provide alerts/notifications specific to legal requirements related to providing Chapter 26.5 services.	HD			
R3681	The system shall track deadlines and provide alerts (e.g., no-show, reports) based on user-defined definitions and parameters.	HD			
R3682	The system shall generate an IEP service plan, identifying the services allowed under the plan.	HD			
R3684	The system shall populate the MH section of the IEP with appropriate information on the completed assessment, and permit individualization and formatting as needed.	HD			
R3685	The system will link goals and objectives from the current treatment plan or Master Service Plan to the IEP.	HD			
R3686	The system shall provide an alert to designated staff (i.e., IEP Coordinator) that the IEP is due for review (i.e., least once a year).	HD			
R3687	The system shall provide school personnel and county staff the capability to track consumer participation on an on-going basis.	HD			
R3688	The system shall provide a letter template (e.g., for no-shows, consumer d/o of treatment, documentation of referral appropriateness).	HD			
R3689	The system shall prohibit billing until certain elements on the IEP are completed.	HD			
R3690	The system shall make billable services required fields to ensure that the provider enters information required to document billable provider services.	HD			

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	Requirement	Prior.	How Met	Avail.	Comments
1.26 Case Management: CCase Management is the process of linking and monitoring the appropriateness of treatment or ancillary services to an individual consumer throughout the consumer's episode of care. Services may include housing, dental care referral, etc. Case management often involves referral to providers outside of MH's purview (e.g., to IMDs, state hospitals, after care). Case management includes the individual wellness recovery action plan (WRAP) that is maintained by the consumer.					
R3906	The system shall track consumers receiving services from community based organizations, including, but not limited to, capturing Service accepted, Service denied, Active/Inactive Status, and Disposition.	HD			
R3907	The system shall permit physicians to have access to the case manager section of the record if required by their role.	HD			
R3909	The system shall allow for flexible presentation of information.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.27 Community Education and Outreach: Initiating communication and contact with the public, and disseminating information to the public, for the purpose of providing health education, health promotion/disease prevention, training and/or skill building, activities, health related screenings, educationally-based early intervention, and awareness of community services and resources.					
R4341	The system shall provide tools for conducting consumer/customer satisfaction surveys, both on-line and through hardcopy collection means.	D			
R4336	The system shall capture and track prevention, early intervention, and outreach activities.	D			
R4337	The system shall capture and track demographics (recipients, viewers, attendees) depending on activity.	D			
R4338	The system shall capture and track non-demographics (e.g., brochures and materials at health care meetings, environmental campaigns, mass media).	D			
R4339	The system shall permit but not require the maintaining of a roster associated with an activity.	D			

Functional Category Title	Section #	Description
Physician Services	28.0	Orders/Results
	29.0	Laboratory Services
	30.0	Medication Management

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How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/A for Not Applicable

Requirement		Prior.	How Met	Avail.	Comments
1.28 Orders / Results: Orders include the issuing and documentation of a physician's request for lab tests, medications, diagnostic exams, special diets, various treatments, services etc. Results include receiving and retaining the outcome of tests that were ordered and performed.					
R3762	The system shall link results to the original order.	HD			
R3763	The system shall generate a notification to authorized users when new results from any clinical assessments, tests, labs, or follow-up services are received into the system.	HD			
R3764	The system shall alert the authorized user (e.g., sponsor, original provider) that results have been received or are overdue.	HD			
R3765	The system shall automatically notify appropriate staff that a result has been received for which an interpretation is required.	HD			
R3766	The system shall flag abnormal values that fall outside of user-defined normal levels, thresholds, or ranges.	HD			
R3767	The system shall accept and capture results into the electronic record using the following methods: on-line entry, inbound FAX, scanned documents.	HD			
R3768	The system shall accept order results into the consumers Electronic Health Record either through on-line (screen) entry by an authorized user and/or import of results captured in system-accepted formats.	HD			
R3769	The system shall provide the capability for an authorized user to indicate in the consumer EHR the location of results on physical media or paper.	HD			
R3770	The system shall support the use of an electronic signature as a means for final approval of any test results (i.e., laboratory).	HD			

How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/

Requirement		Prior.	How Met	Avail.
1.29 Laboratory Services: Allowing providers to order lab test, both manually and electronically, and furnish accurate lab tes electronic (i.e., FAX or structured data) format that can be incorporated in to the consumer record.				
R3812	The system shall integrate laboratory order entry as part of the electronic order entry.	HD		
R3811	The system should generate lab slips.	HD		
R3816	The system shall electronically transmit a HIPAA compliant secure order to a County-internal or external laboratory.	HD		
R3803	The system shall allow a designated user to manually enter lab results into the consumer record.	HD		
R3800	The system shall provide the capability for the graphical display of laboratory results according to user-defined time periods, value ranges, and number of specified result sets.	HD		
R3806	The system shall provide the capability for an authorized user to compare current and historical lab results using the appropriate reference ranges associated with each lab result (i.e., by date and type of test).	HD		
R3801	The system shall maintain the current and historical reference ranges associated with specific laboratory tests and results.	HD		

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A for Not Applicable

Comments
st results in response to that order on a timely basis in

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Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/A for Not Applicable

	Requirement	Prior.	How Met	Avail.	Comments
	1.30 Medication Management Services: Accepting and fulfilling a prescription order, performing drug utilization reviews (DUR), billing for the pharmaceutical service, and maintaining a record of the transaction. SCMH does not operate a pharmacy but must still manage the acquisition, distribution, and control of all pharmaceutical products, including samples. The process may also include educating consumers and providers about drugs or advise providers on drug selection.				
R3820	The system shall support entry of original pharmacy orders directly into the system.	HD			
R3821	The system shall permit the update or edit of all pertinent fields of a pharmacy order (e.g. select another drug).	HD			
R3822	The system shall support renewal of an order (e.g. stop-dated orders, transfer orders)	HD			
R3823	The system shall support cancellation or discontinuation of an order.	HD			
R3824	The system shall reject invalid/inappropriate orders and route information to appropriate users to resolve.	HD			
R3825	The system shall support order holds for specified term with automatic resumption and open-ended terms.	HD			
R3827	The system shall electronically transmit a HIPAA-compliant secure prescription to County-approved pharmacies.	HD			
R3828	The system shall provide the ability to print a prescription.	HD			
R3829	The system shall make treatment plans and progress notes accessible and viewable during the prescription-writing process.	HD			
R3832	The system shall support review of an order by pharmacist.	HD			
R3833	The system shall support verification and approval of a pharmacy order as entered.	HD			
R3834	The system shall support online drug interaction checks for drug/drug interactions, drug/lab, drug/food, and drug/allergy.	HD			
R3835	The system shall provide alerts for drug-drug, food-drug, drug-allergy interactions, etc.	HD			
R3836	The system shall support ordering injectables.	HD			
R3837	The system shall comply with Federal Medicaid Guidelines and State regulations for tamper-proof prescriptions.	HD			
R3838	The system shall print prescription on tamper-proof paper without having to change the paper tray.	HD			
R3839	The system shall track medications received, dispensed, returned, etc.	HD			
R3840	The system shall provide notification of required follow-up activities for the administration of emergency medications, PRNs, and STATs within user-defined timeframes.	D			
R3841	The system shall generate a single medication profile for each consumer that is viewable on a single screen	HD			
R3843	The system shall generate and maintain an electronic medication log.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3845	The system shall generate medication consent forms, capture consumer consent via electronic signature, and retain signed consent forms.	HD			
R3847	The system shall have the ability to document and report various clinical monitors, e.g. Adverse Drug Reaction, Medication Error, Non-Formulary Drug request.	HD			
R3848	The system shall support the ability to add patient specific comments (e.g., reactions to medications) and identify the user who generated the comment.	HD			
R3850	The system shall automatically notify staff when medication is ready for pick up.	HD			
R3851	The system shall automatically notify staff after the patient has picked up a medication.	HD			
R3852	The system shall provide the capability for an authorized user to enter information regarding the fulfillment of a pharmacy order (whether through dispensing or administration) directly into a consumer medical record.	HD			
R3853	The system shall provide the capability for an authorized user to access and view pharmacy orders over time for a user-defined consumer or population to analyze drug usage and dispensing/administration patterns for that consumer or population.	HD			
R3854	The system shall support pharmacy order renewals without re-entering them into the system, including conversion of existing inpatient orders to outpatient orders and conversion of existing outpatient orders to inpatient/admitting orders.	HD			
R3855	The system shall generate a notification to an authorized user when pharmaceutical orders are entered into the system.	HD			
R3857	The system shall prompt the doctor to obtain a medication consent in user-defined situations.	HD			
R3858	The system shall support the Treatment Authorization Request (TAR) for medication requests.	HD			
R3859	The system will maintain a single medication profile for each consumer that includes information about medications prescribed by the County, those being taken but prescribed by another provider, drug allergies, and other related and relevant information for consumer protections.	HD			
R3860	The system shall link directly to consumer profiles in the County pharmacy and other retail pharmacies with whom SCMH has a business relationship.	HD			
R3861	The system shall automatically update the medication log based on physician orders.	HD			
R3862	The system shall provide an electronic record of consumer sign-off on Medication Consent Forms.	HD			
R3863	The system shall contain or access the JV220(A) Form for physicians seeking authority from the court to prescribe psychotropic medications to wards of the court who are placed outside of their home.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3864	The system shall support the PHF REISE process (3 forms to Court for approval) for medications administered to juveniles.	D			
R3865	The system shall provide an alert to the physician if a consumer reports side effects attributable to prescribed medications.	HD			
R3866	The system shall be capable of interfacing with external drug information sources.	HD			
R3867	The system shall require that a physician document the reason a medication was discontinued.	HD			
R3868	The system shall retain information about medications that were tried and considered ineffective, and medications that were discontinued for other reasons.	HD			
R3870	The system shall have online drug interaction, duplication of therapy, allergy alerts that are provided to an authorized user at the points of order entry and validation of the order.	HD			
R3871	The system shall produce drug ID description on label as required by regulation and the ability to edit drug ID descriptions at point of order entry for each fill/refill.	HD			
R3872	The system shall have the capability to establish and meet time-specific reporting requirements as established by regulation and accreditation standards including CURES (controlled substance utilization Review and evaluation system).	HD			
R3873	The system shall have the ability to perform medication dose calculations.	HD			
R3874	The system shall generate alerts to designated recipients (e.g., consumer care team and physician) of pertinent medication clinical information.	HD			
R3875	The system shall permit an authorized member of the consumer care team to access a common consumer medication history in order to deliver appropriate and/or coordinated pharmaceutical care.	HD			
R3876	The system shall permit OP or retail pharmacists to approve an order as entered or select another drug as needed.	HD			
R3877	The system shall support control of Injectible medications.	HD			
R3881	The system shall maintain and update a locally-defined formulary and display first-choice drugs.	HD			
R3883	The system shall support Drug Formulary Management, with live updates to formularies and drug alternatives available via the solution provider or another service (e.g., First Data Bank).	D			
R3886	The system shall manage inventory for samples drugs, including tracking and providing alerts for those medications that are reaching or have reached expiration dates.	HD			
R3887	The system shall use bar code technology to manage inventory of drug samples.	D			
R3888	The system shall maintain a log and perpetual inventory of drug samples.	HD			
R3890	The system shall maintain pharmacy inventory control across multiple County	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3891	The system must be able to track sub-inventories for controlled substances	HD			
R3894	The system shall have the ability to generate medication drug profiles.	HD			
R3895	The system shall have the ability to generate drug monographs.	HD			
R3896	The system shall be capable of printing out educational information on medications being administered or dispensed.	HD			

Functional Category Title	Section #	Description
Institutional Care Services	31.0	Bed Management
	32.0	Census

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Requirement		Prior.	How Met	Avail.	Comments
1.31 Bed Management: Tracking availability of beds in County-owned, -managed, or -contracted consumer accommodations by type of facility (e.g., inpatient 24 hour care facility, apartments) and to generate rosters by facility that may be used to support resource management and payer requirements.					
R3401	The system shall provide a consolidated history of a consumer's movement related to residential placement and inpatient admissions approved by the County.	D			
R3404	The system shall track entry and exit dates of each housing placement for each consumer.	D			
R3405	The system shall track what type of housing is being used by the consumer on each housing placement.	D			
R3406	The system shall track total length of stay (number of days occupied), counting day entering placement, but not counting day of discharge.	D			
R3407	The system shall track and report benchmarks of housing placement (e.g., at the 30-day mark, 6-month mark and 12-month mark).	D			
R3408	The system shall track where consumer entered and exited housing placement, including who referred them and where they went after placement.	D			

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Requirement		Prior.	How Met	Avail.	Comments
1.32 Census: Provide official count of the number of active consumers or patients as of a specific date/time or date range. The census is essential to manage capacity and to comply with payer requirements that may be driven by room and board. Some programs require a daily census (e.g., inpatient PHF and intensive day care services) whereas others may require less frequent, periodic census counts.					
R3971	The system shall capture and track census for consumers in inpatient settings.	D			
R3972	The system shall capture and track census for consumers in outpatient settings.	D			
R3973	The system shall capture and track residential and inpatient consumers by unit, room and bed.	D			
R3974	The system shall generate Facility Alphabetical Rosters showing consumer name and location within facility, physician, insurance, and phone number	D			

Functional Category Title	Section #	Description
Oversight and Compliance (QI)	33.0	Compliance/Audit
	34.0	Reporting
	35.0	Performance Quality Improvement

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How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
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Requirement		Prior.	How Met	Avail.	Comments
1.33 Compliance/Audit: Ensuring that SCMH meets accreditation, regulatory, legal, and payer requirements.					
R4111	The system shall provide the capability to track County compliance with documentation standards and regulations.	HD			
R4112	The system shall permit the definition, compilation, and maintenance of necessary data for compliance reporting required by State, Federal, and other agencies that regulate County behavioral health activities.	HD			
R4113	The system shall provide the capability for authorized staff to define required activities and establish a workflow template for a given type of audit that can be saved for reuse.	HD			
R4114	The system shall generate and send notification(s) to County staff involved in audit activities regarding County-defined audit events and compliance status.	HD			
R4115	The system shall allow authorized users to query the status of activities related to specific audits.	HD			
R4116	The system shall generate and send notifications to authorized users when audit activities are approaching deadlines.	HD			
R4117	The system shall generate reports specific to audit status, outstanding activities, and percent completion of specific audits.	HD			
R4118	The system shall provide the capability for authorized users to enter information regarding resolution of audit activities	HD			
R4119	The system shall provide the capability for authorized users to enter corrective actions resulting from audits	HD			
R4120	The system shall provide the capability for authorized users to enter and append audit results.	HD			
R3172	The system shall allow an authorized user to enable or disable auditing for groups of related events in order to demonstrate evidence of compliance with specific regulations and/or policies.	HD			
R3147	The system shall have electronic mechanisms to corroborate that electronic protected health information has not been altered or destroyed in an unauthorized manner.	HD			
R3151	The system shall have security measures that guard against unauthorized access to electronic protected health information that is being transmitted over an electronic communications network.	HD			
R3173	The system shall require the user to change the password after their next successful login when their login account has been reset by support (e.g., system administrator, helpdesk).	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R3176	The system shall prevent the reuse of passwords previously used within a specific (configurable) timeframe (i.e., within the last X days, etc. - e.g. "last 180 days"), or shall prevent the reuse of a certain (configurable) number of the most recently used passwords (e.g. "last 5 passwords").	HD			
R3177	The system shall not display passwords while being entered.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.34 Reporting: Aggregating financial, operational, and/or clinical data into meaningful information that facilitates decision-making, supports compliance/auditing needs, and meets mandated reporting requirements (e.g., CSI, CalOMS, and Medi-Cal cost reports). Standard reporting adheres to a pre-determined format and data types and is produced on a routine basis. Ad-hoc reporting generates reports containing user-requested data on an as-needed or on-demand basis. Reporting support both Oversight and Compliance as well as Planning and Research (e.g. decision support and data warehouse operations).					
R4122	The system shall provide all standard reports as defined by the County.	HD			
R4126	The system shall provide reports on contact statistics (e.g., volume and type of inquiries, turnaround time, and number of abandoned calls) for contact management (i.e., Central Access) and call intake activities.	HD			
R4127	The system shall provide reports on wait-listed consumers.	HD			
R4128	The system shall generate statistical reports to the State Department of Alcohol And Drug Programs identifying program census of consumers treated and/or awaiting drug and alcohol treatment, including the Drug and Alcohol Treatment Access Report (DATAR).	D			
R4129	The system provides reporting capability to identify consumers that may be eligible for Medi-Cal based on multiple criteria.	HD			
R4130	The system shall provide reporting capability that identifies any changes in a consumer's eligibility for service (by payor, funding source).	HD			
R4131	The system shall provide reporting capability that identifies consumer eligibility for coverages other than Medi-Cal (e.g., Medicare, insurance, private pay).	HD			
R4132	The system shall generate reports that identify aid code(s) by consumer.	HD			
R4133	The system shall generate appointment disposition reports by clinic or by provider for County-defined date range to include: Appointments kept, Cancellations, No-shows.	HD			
R4134	The system shall produce reports listing appointments by provider for user-defined date ranges.	HD			
R4135	The system shall provide a roster of current staff with contact information for routine communication.	D			
R4137	The system shall track and report on statistics regarding authorizations including: Submissions, Approvals, Denials, Provider type, Age of authorization, Other parameters as defined by the County	HD			
R4138	The system shall provide reports that indicate the trending of authorizations by the following: Referring provider. Referred to provider, Referred to provider specialty, Authorization status (approved/denied/pended), Any combinations of above	HD			
R4139	The system shall produce authorization productivity reports by authorizing user.	HD			
R4140	The system shall produce authorization turnaround report.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R4141	The system shall provide standard reports on unauthorized services by the following parameters: consumer, Provider, Status of authorization (none, pending, denied, violated), Service Provider not authorized for (facility, program, payor, population, service)	HD			
R4142	The system shall track and report on the number of open cases/episodes by: Active consumers or programs, Inactive consumers or programs, Provider, location, and diagnosis, Unduplicated	HD			
R4143	The system shall track and report on the number of case/episodes opened and/or closed during a user-defined period of time by provider, location, and diagnosis.	HD			
R4144	The system shall track and report on a consumer by: Number of cases involving consumer, Diagnosis (e.g., Primary, Secondary, Tertiary; Axis I-V), Location where services are being provided to consumer	HD			
R4145	The system shall capture and report each consumer who has been evaluated for 5150 status and disposition of each evaluation.	HD			
R4146	The system shall track and report on the number of cases, either by program or total, assigned to a provider (e.g., Network and County employed providers).	HD			
R4147	The system shall generate reports that indicate active cases by funding source	HD			
R4148	The system shall track and report on service activity for user-defined time periods by one or more of the following parameters: consumer, provider, Facility, Service, Dates of service, Other County-defined parameters	HD			
R4149	The system shall provide a standard report on services without supporting progress notes.	HD			
R4150	The system shall capture and generate reports on the number of consumers receiving services per location.	HD			
R4151	The system shall track and report consumers currently receiving services in any Drug Courts, including but not limited to: Adult (Levels 1, 2, 3), Juvenile, Mental Health, Dependency, etc.)	D			
R4152	The system shall track consumers by housing arrangement to include: Assisted Living, Board and Care, Transitional Housing, State/Private Hospital, Institute of Mental Disease (IMD)	HD			
R4153	The system shall generate bed rosters by unit and occupancy reports for all Agency owned or managed beds.	HD			
R4154	The system shall automatically calculate and generate Length of stay (LOS) reports where LOS is calculated by counting the day entering placement, but not counting the day of discharge.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R4155	The system shall automatically generate a 26.5/AB 3632 Assessment Report that shows all consumers in this category by site and status.	HD			
R4156	The system shall provide the capability for authorized users to generate a report of information disclosures for user-defined time periods.	HD			
R4157	The system shall generate reports related to consumer movement (i.e., ADT).	HD			
R4158	The system needs to be able to report service and outcome information related to special populations.	HD			
R4160	The system shall generate a history of: Payments received, Treatments, Date of Billing.	HD			
R4161	The system shall generate a history of Medi-Cal, Medicare, Insurance, Private Pay, Other.	HD			
R4162	The system shall generate a history of Balance and reconcile receivables with receipt number.	HD			
R4163	The system shall have the ability to itemize and extract costs, bills, receivables, and collections by Location, Program, Provider, Service Type, Case Number, Funding Source, Service Function Code, Mode of Service, and Legal Entity.	HD			
R4164	The system shall maintain Case cost information by: Individual consumer (listed from high to low cost).	HD			
R4165	The system shall maintain Case cost information by: Family (listed from high to low cost of service).	HD			
R4166	The system shall maintain Case cost information by: Individual provider (both contract Network private providers and County employees).	HD			
R4167	The system shall maintain Case cost information by: Stratified case type (e.g. less intensive or more intensive).	HD			
R4168	The system shall maintain Case cost information by: Region of the County (e.g., ZIP code).	HD			
R4169	The system shall maintain Case cost information by: Facility or school location at which services are provided (site location table).	HD			
R4170	The system shall generate claims report that itemizes: Claims paid, Claims denied, Claims suspended and reasons (e.g., suspended due to internal edits or from payors).	HD			
R4171	The system shall permit sorting claims report by provider, and by date range.	HD			
R4172	The system shall generate reports based on payor type to include: Medicare, Medi-Cal, private pay, Healthy Families, and other payor types not yet identified.	HD			
R4173	The system shall itemize, extract, and report on costs by one or more of the following parameters: Service Location, Program, Provider, Service type, Case number, Funding Source, Date/Time (individual or range).	HD			
R4174	The system shall summarize non-billable activities by provider, by staff, and by service.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R4175	The system shall compile service units and charges into the Medi-Cal and Medicare cost reporting categories to produce reports that will support the development of these annual cost reports.	HD			
R4176	The system shall generate appropriate reports as needed and on a timely basis (via paper forms, on-line screen, etc).	HD			
R4177	The system shall generate reports with summary-level data according to user-defined criteria, such as subtotals by payor, payor class, program, location, etc.	HD			
R4178	The system shall provide detailed aged accounts receivable reports with user-defined sort and subtotal criteria including payor, provider, consumer, program, location, etc.	HD			
R4179	The system shall report the total amount billed by: Case/consumer	HD			
R4180	The system shall report the total amount billed by: Number of appointments	HD			
R4181	The system shall report the total amount billed by: 100% appointment / billing, (exception report of appointment not billed)	HD			
R4182	The system shall report the total amount billed by: The entire history of a consumer account.	HD			
R4183	The system shall permit authorized staff to print or display Bills and re-bills to consumers and/or third-party payors (individually or batch).	HD			
R4184	The system shall permit authorized staff to print or display Notification to consumer of provider claim approval.	HD			
R4185	The system shall generate a report on total amounts billed and total amounts received in a month.	HD			
R4186	The system shall generate an account-specific A/R aging report for claims over: 30 days, 60 days, 90 days, 80 days, User-defined time periods.	HD			
R4187	The system shall generate A/R Aging Reports by consumer, by program/service, and by funding source that include: amount billed, amount received, amount adjusted.	HD			
R4188	The system shall generate a report of denied and/or rejected claims with the reasons for denial/rejection.	HD			
R4189	The system shall generate exception reports.	HD			
R4190	The system shall generate unbilled claims status report.	HD			
R4191	The system shall generate rejected claims status report.	HD			
R4192	The system shall generate a report that reflects payments received and credited to consumer accounts by payor source and date or date range.	HD			
R4193	The system shall provide a report on all insurance billing and reimbursement activity for a specific consumer.	HD			
R4194	The system shall provide reports showing the status of staff credentialing and licensing, including expiration dates.	HD			

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Requirement		Prior.	How Met	Avail.	Comments
R4196	The system shall automatically generate State-required reports using prescribed data elements, formats, and frequencies.	HD			
R4197	The system shall generate error reports to detect missing or incomplete data elements prior to electronic transmittal to State, e.g. null fields.	HD			
R4201	The system shall produce a MHS Medi-Cal Cost Report.	HD			
R4323	Payment records are updated to ensure accuracy and reliability. Payment records are posted to the general ledger, A/P and A/R as needed (e.g., recovery operations).	HD			

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Requirement		Prior.	How Met	Avail.	Comments
1.35 Performance Quality Improvement (PQI): Monitoring processes that affect the quality of consumer care processes and/or outcomes. PQI identifies areas that need improvement, develops solutions to rectify deficiencies, optimizes resource utilization, and improves processes and outcomes. PQI efforts are integrated with staff training.					
R4106	The system shall provide an audit trail on checks received.	HD			
R4107	The system shall support electronic audits regardless of a user's current location (i.e., not requiring having to go to the clinic).	HD			
R4108	The system shall provide automatic quality assurance checks based on business rules (e.g., system automatically tracks compliance with requirement to provide consumer an appointment for service within 21 days of the first contact based on system calculation).	HD			
R4109	The system shall generate reports that identify discrepancies where the progress note date does not match the attendance date.	HD			
R4110	The system shall permit authorized users at Community-Based Organizations (CBOs) to access compliance information.	HD			
R4326	The system shall permit the creation of a variety of outcome measurement instruments.	HD			
R4327	The system shall incorporate a variety of 3rd-party licensed instruments that have been authorized for use.	HD			
R4328	The system shall support Locally-defined scoring protocols that can be used to summarize outcome instrument data.	HD			
R4329	The system shall permit Clinical review of outcome score trends over time (e.g., through on-line queries).	HD			
R4330	The system shall capture Outcome data elements.	HD			
R4331	The system shall capture and track age group specific (e.g., adult, child, elder, family) Outcome data (e.g., beginning and ending Outcomes).	HD			
R4332	The system shall support data mining, data analysis, data validation, reporting, queries, and billing.	HD			
R4349	The system shall capture and report on all information required by Federal, State, and local agencies, such as penetration rates, telephone access, and CSI data, to assess performance of the call intake process and improve the quality of service.	HD			

Functional Category Title	Section #	Description
Planning and Research	34.0	Reporting

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How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
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Requirement		Prior.	How Met	Avail.	Comments
1.34 Reporting: Aggregating financial, operational, and/or clinical data into meaningful information that facilitates decision-making, supports compliance/auditing needs, and meets mandated reporting requirements (e.g., CSI, CalOMS, and Medi-Cal cost reports). Standard reporting adheres to a pre-determined format and data types and is produced on a routine basis. Ad-hoc reporting generates reports containing user-requested data on an as-needed or on-demand basis. Reporting support both Oversight and Compliance as well as Planning and Research (e.g. decision support and data warehouse operations).					
R4334	The system shall provide for graphical presentation of results.	HD			
R4369	The system shall provide access to all information needed for External Quality Review Organization (EQRO) activities, specifically including 1) consumer zip code, 2) consumer demographics, and 3) the fact that the consumer is a MH client.	HD			
R4123	The system shall provide standard reports that present a variety of views of County administrative and clinical operations (e.g., monthly trend reports, clinician comparison reports) that provide summarized management-related data and that support tactical and strategic decision-making.	HD			
R4343	The system shall have robust analysis and reporting capability (e.g., comparing pre- and post-test data).	HD			
R4344	The system shall support the ability to chart outcome data (e.g., pre- post- data entry).	HD			
R4345	The system shall visually present data for analysis and reporting.	HD			

Functional Category Title	Section #	Description
Health Plan Actvities	11.0	Provider Portal
	36.0	Licening/Credentialing

How Met: Select one of the following -- Std. for Standard, Mjr for Major, Min. for Minor, N/A for Not Available
Avail: For Std. ONLY select one of the following -- Prod. For In Production, Beta for In Beta, Dev. For In Development, N/A for Not Applicable

Requirement		Prior.	How Met	Avail.	Comments
1.36 Licensing/Credentialing: Credentialing is the administrative process of validating the qualifications of licensed professionals (including H&SS staff, contract and network provider staff, organizational members or organizations) and checking their background and legitimacy. Credentialing is undertaken at the beginning of employment/contract (initial granting) and at regular intervals thereafter (re-credentialing).					
R4213	The system shall track the status of credentials for individual clinicians, both County staff and contract providers.	HD			
R4214	The system shall track the status of certification for provider facilities and provide notice for approaching expirations.	HD			
R4216	The system shall capture and track NPI information (organizational provider, service facility, individual).	HD			
R4218	The system shall automatically generate expiration letters to providers (e.g., expiration of licensure, Drug Enforcement Administration (DEA) number, professional liability insurance) according to user-defined number of days prior to expiration date.	D			
R4219	The system shall store credentialing information for a provider and automatically prompt for updates at intervals determined by the County.	D			
R4220	The system shall capture and track identification numbers and effective dates for provider license, Drug Enforcement Administration (DEA) number, professional liability insurance, etc.	HD			
R4221	The system shall automatically notify the County of providers who have not been re-credentialed by a required date.	D			
R4222	The system shall automatically prompt to verify providers are re-credentialed by the required date.	D			
R4223	The system shall support Federal and State requirements related to professional and industry-specific licensing and credentialing.	D			
R4224	The system shall provide the capability to track staff qualifications, including credentials, privileges, and licensure, and currency requirements for licensed/certified staff and contract providers.	D			
R4225	The system shall provide the capability for an authorized user to review license, credential, and privilege expiration dates for licensed/certified staff and contracted individuals.	D			
R4226	The system shall provide the capability for an authorized user to configure the time period prior to a specific expiration date when an alert is to be sent.	D			

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Requirement		Prior.	How Met	Avail.	Comments
R4227	The system shall provide an alert to affected staff or contract provider when current license and/or credentials approach expiration deadlines.	D			

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Requirement		Prior.	How Met	Avail.	Comments
1.37 Notice of Actions (NOAs)/Appeals: Complaints, grievances, appeals, Notice of Actions, and State Hearings represent escalating levels of action available (depending on payer, program, and county policies and procedures) that can be taken when a consumer, provider, family member, or advocate contests a decision concerning denial of services or other issues deemed as unacceptable. Most activities associated with this process will not involve the EHR. However, the system will need to generate NOAs associated with denial of provider claims (NOA-C) and reduction in services (NOA-D).					
R3954	The system shall permit authorized staff to print or display a bilingual Notice of Action (NOA) and other service denials to consumers based upon coded reasons.	HD			
R4205	The system shall automatically generate a Notice of Action, as appropriate, based on information entered when the service was requested.	HD			
R4206	The system shall automatically generate a Notice of Action, as appropriate, if a network provider rendered a service without receiving prior approval. (Hospitalizations)	HD			
R4319	For denied payments, the system shall automatically create the Notice of Action-C (NOA-C) using information on the Explanation of Benefit.	HD			

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	Requirement	Prior.	How Met	Avail.	Comments
	1.38 Provider Contract Management: Provider contract management involves the process of monitoring contractual agreements between service organizations, providers, and various agencies that facilitate service delivery and financial obligations. Contract maintenance involves keeping contract terms and conditions accurate, up-to-date, and in compliance with applicable rules and regulations. Track contracts with network providers and CBOs based on clinical outcome measures defined by the program-- measures depend on type of program. Includes tracking the arbitration/dispute progress, insurance requirements, quality and utilization performance, financial condition (reimbursement, payment, cash flow), licensure status and other factors important in monitoring provider contract-compliance. A contract is a legal, binding agreement that stipulates terms and conditions between the County and another party. One of the major objectives for contract management is the development of a business partnership with providers to ensure the delivery of quality services, proper reimbursement, risk mitigation, facilitation of administrative functions (e.g., authorizations, claims), and availability of funding.				
R4231	The system shall allow the design and implementation of workflows specific to the type of contract being managed.	D			
R4233	The system shall maintain a rate schedule by provider, whether County staff or contract provider.	D			
R4234	The system shall record and track communications with provider organizations and individual clinicians, such as notes related to provider requests, complaints, and contacts initiated by County staff.	D			
R4235	The system shall indicate that the provider has been sent current handbooks and other materials.	D			
R4236	The system shall indicate receipt of required documentation from provider.	D			
R4237	The system shall support a centralized repository for all contract-related templates and documentation (e.g., contract templates).	D			
R4238	The system shall maintain all required information on each contract being managed (e.g., contract status, term/duration, contractor information, financial information, amendment information, termination date and reason).	D			
R4239	The system shall allow the design and implementation of workflows specific to the type of contract being managed.	D			
R4240	The system shall provide an audit capability that tracks all revisions and/or changes to an original approved contract.	D			
R4241	The system shall generate and provide reminders for events requiring user attention (e.g., contracts pending renewal, fee schedule changes, deadlines for submitting information, invoice approval).	D			
R4242	The system shall reconcile contract amount (e.g., invoices, payments) with amount encumbered for that contract.	D			
R4243	The system shall provide a complete revision history to an approved contract package upon request.	D			

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Requirement		Prior.	How Met	Avail.	Comments
R4244	The system shall incorporate workflow to design, implement, and manage standardized processes for contract management.	D			
R4245	The system shall provide a checklist of all requirements that must be met before a contract is approved or that are needed to ensure that a contract will continue in force (e.g., licensing / credentialing requirements needed for Medi-Cal contracts.)	D			
R4246	The system shall generate and provide alerts when specific contract requirements are not being met for contract approval or renewal.	D			
R4247	The system shall provide a notification when a contractor's date of certification approaches expiration, has expired, or been revoked.	D			
R4248	The system shall provide a notification when a contract approaches expiration, has expired, or been revoked.	D			
R4249	The system shall support configurable workflow to route contract request and/or contract electronically to obtain required approvals.	D			
R4250	The system shall provide for electronic approval of contract request and/or contract.	D			
R4251	The system shall permit an approver for a contract request and/or contract to delegate his/her approval authority as needed.	D			
R4252	The system shall provide the capability for an authorized user to query the status of a specific contract request and/or contract.	D			
R4253	The system shall allow an authorized user to create and maintain single-case agreements. (Note: Single-case agreements are those established when a non-contracted hospital admits a PHC member and the County contracts with the hospital for a singke case for consumer if not inclusive with attending physician. Also refers to foster children under SB785.)	D			
R4255	The system shall retain historical rate information.	D			

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	Requirement	Prior.	How Met	Avail.	Comments
	1.39 Provider Network Management: Provider network management ensures that the proper mix of providers (clinicians) is available to deliver necessary, covered services to consumers throughout the service area. Provider network management involves determining consumer needs, screening potential provider applicants, verifying potential provider applicants' credentials, license, and qualifications, writing contracts, ensuring contract compliance, and re-credentialing and renewing provider contracts as appropriate to maintain the provider network.				
R4257	The system shall maintain a database of providers to identify gaps in service area needs.	HD			
R4270	The system shall capture and maintain detailed practice information for clinicians in the provider network (as well as County staff), including data such as provider status (e.g., provider name, type, address, ages served, therapeutic modalities, experience with cultural groups, experience with spiritual groups, languages spoken, specialty services, specific areas of practice, and whether accepting new referrals).	D			
R4271	The system shall automatically populate user-defined forms, lists, and reports from data entered in to the provider payment database (e.g., the Public List, Mailing List, Regional List, and Scope of Practice Sheet).	HD			