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EMR 102: Ambulatory EHR Criteria and Features

What is an AMR?

Ambulatory medical record (AMR): An electronically stored patient medical record that includes all surgeries and care that do not involve an admission to a hospital. AMRs and related activity are stored in electronic databases (EMR/EHR) and are accessible by doctors and other medical professionals so they can view a patient's complete and accurate medical history.

Ambulatory EHR products must meet all mandatory requirements as defined in the Standards and Certification Criteria Final Rule (STANDARD AMBULATORY EHR CRITERIA) in order to be classified as a "Complete EHR". Complete EHR products listed on EMRapproved.com will have features listed as "All Standard Certified EHR Features", plus all of the criteria applicable to a type of practice setting.

Standard Ambulatory EHR Criteria:

(A) Computerized provider order entry

Enable a user to electronically record, store, retrieve, and modify the following types: medications, laboratory; and radiology/imaging.

(B) Electronic prescribing

Enable a user to electronically generate and transmit prescriptions and prescription-related information.

(C) Record Demographics

Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, gender, race, ethnicity, and date of birth.

(D) Patient reminders

Enable a user to electronically generate a patient reminder list for preventive or follow-up care according to patient preferences based on the data elements included in: Problem list, Medication list, Medication allergy list, Demographics, and Laboratory test results.

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(E) Clinical decision support

1. Implement rules. Implement automated, electronic clinical decision support rules (in addition to drug-to-drug and drug allergy contraindication checking) based on the data elements included in: problem list, medication list, demographics and laboratory test results.

2. Notifications. Automatically and electronically generate and indicate in real time, notifications and care suggestions based on clinical decision support rules.

(F) Electronic copy of health information

Enable a user to create an electronic copy of a patient's clinical information, including diagnostic test results, problem list, medication list, medication allergy list and laboratory test results. This must be in human readable format.

(G) Timely access

Enable a user to provide patients with online access to their clinical information, including lab test results, problem list, medication list, and medication allergy list.

(H) Clinical summaries

Enable a user to provide clinical summaries to patients for each office visit that include diagnostic test, results, problem list, medication list, medication allergy list in human readable format.

(I) Exchange clinical information and patient summary record

Electronically transmit, receive, and display a patient's summary record, from other providers and organizations including diagnostic tests results, problem list, medication list, and medication allergy list.

(J) Calculate and submit clinical quality measures

Electronically calculate all of the core measures and in addition three clinical quality measures specified by the CMS for eligible professionals.

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