

Test Procedure for §170.306 (d)(2) Electronic Copy of Health Information

This document describes the draft test procedure for evaluating conformance of complete EHRs or EHR modules¹ to the certification criteria defined in 45 CFR Part 170 Subpart C of the Final Rule for Health Information Technology: Initial Set of standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology as published in the Federal Register on July 28, 2010. The document² is organized by test procedure and derived test requirements with traceability to the normative certification criteria as described in the Overview document located at http://healthcare.nist.gov/docs/TestProcedureOverview_v1.pdf. The test procedures may be updated to reflect on-going feedback received during the certification activities.

The HHS/Office of the National Coordinator for Health Information Technology (ONC) has defined the standards, implementation guides and certification criteria used in this test procedure. Applicability and interpretation of the standards, implementation guides and certification criteria to EHR technology is determined by ONC. Test procedures to evaluate conformance of EHR technology to ONC's requirements are defined by NIST. Testing of EHR technology is carried out by ONC-Authorized Testing and Certification Bodies (ATCBs), not NIST, as set forth in the final rule establishing the Temporary Certification Program (*Establishment of the Temporary Certification Program for Health Information Technology, 45 CFR Part 170; June 24, 2010.*)

Questions about the applicability of the standards, implementation guides or criteria should be directed to ONC at ONC.Certification@hhs.gov. Questions about the test procedures should be directed to NIST at hit-tst-fdbk@nist.gov. Note that NIST will automatically forward to ONC any questions regarding the applicability of the standards, implementation guides or criteria. Questions about functions and activities of the ATCBs should be directed to ONC at ONC.Certification@hhs.gov.

CERTIFICATION CRITERIA

This Certification Criterion is from the Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology Final Rule issued by the Department of Health and Human Services (HHS) on July 28, 2010.

§170.306 (d) Electronic copy of health information

- (2) Enable a user to create an electronic copy of a patient's discharge summary in human readable format and on electronic media or through some other electronic means

¹ Department of Health and Human Services, 45 CFR Part 170 Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, Final Rule, July 28, 2010.

² Disclaimer: Certain commercial products are identified in this document. Such identification does not imply recommendation or endorsement by the National Institute of Standards and Technology.

Per Section III.D of the preamble of the Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, Final Rule where the electronic copy of health information certification criterion is discussed:

- “We do not specify that electronic media such as thumb drives or CDs must be used. An eligible hospital will be able to determine, consistent with its security posture, if certain electronic media is permissible and if so, what types. It will also be able to determine the means and location through which an electronic copy may be provided, e.g., at the records management department or office. As the commenter suggested, a patient portal would be an acceptable mechanism to provide an electronic copy.”
- “At a minimum, Certified EHR Technology must be capable of generating an electronic copy of health information that includes the elements specified by the certification criterion in an electronic copy. We do not specify the time period for which the electronic copy must cover as a condition of certification.”

INFORMATIVE TEST DESCRIPTION

This section provides an informative description of how the test procedure is organized and conducted. It is not intended to provide normative statements of the certification requirements.

This test evaluates the capability for a Complete EHR or EHR Module to create an electronic copy of a patient’s discharge summary in human readable format and on electronic media or through some other electronic means.

The Vendor supplies the test data for this test procedure.

The test procedure consists of one section:

- Create - evaluates the capability to create a copy of a patient’s discharge summary in human readable format and on electronic media or through some other electronic means
 - The Tester enters the Vendor-supplied test data for discharge summary into a patient’s EHR
 - The Tester uses the Vendor-identified function(s) to create a copy of this patient clinical information on electronic media or via another electronic means
 - The Tester validates that the discharge summary data rendered on the electronic media or via other electronic means are complete and in conformance

REFERENCED STANDARDS

None

NORMATIVE TEST PROCEDURES

Derived Test Requirements

DTR170.306.d.2 – 1: Create an electronic copy of a patient's discharge summary

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Required Vendor Information

VE170.306.d.2 – 1.01: Vendor shall identify a patient with an existing record in the EHR to be used for this test

VE170.306.d.2 – 1.02: Vendor shall identify the EHR function(s) that are available to 1) select the patient, 2) enter patient's discharge summary, 3) create a copy of a patient's discharge summary on electronic media or other electronic means

Required Test Procedure

TE170.306.d.2 – 1.01: Tester shall select patient discharge summary data from Vendor-supplied test data

TE170.306.d.2 – 1.02: Using the EHR function(s) identified by the Vendor, the Tester shall select the patient's existing record and enter patient discharge summary data

TE170.306.d.2 – 1.03: Using the EHR function(s) identified by the Vendor, the Tester shall create a copy of the patient's discharge summary data

TE170.306.d.2 – 1.04: Using the NIST-supplied Inspection Test Guide, the Tester shall verify that the copy of the patient's discharge summary data has been created correctly and without omission

Inspection Test Guide

IN170.306.d.2 – 1.01: Tester shall verify that the patient discharge summary data are entered correctly and without omission

IN170.306.d.2 – 1.02: Using the data in the Vendor-supplied Test Data, Tester shall verify that all of the patient discharge summary data are stored in the patient's record

IN170.306.d.2 – 1.03: Using the data in the Vendor-supplied Test Data, Tester shall verify that the copy of the patient discharge summary data has been created correctly and without omission on electronic media or other electronic means

TEST DATA

This Test Procedure requires the vendor to supply the test data. The Tester shall address the following:

- Vendor-supplied test data shall ensure that the functional and interoperable requirements identified in the criterion can be adequately evaluated for conformance
- Vendor-supplied test data shall strictly focus on meeting the basic capabilities required of an EHR relative to the certification criterion rather than exercising the full breadth/depth of capability that an installed EHR might be expected to support
- Tester shall record as part of the test documentation the specific Vendor-supplied test data that was utilized for testing

TD170.306.d.2: Example of a discharge summary that could be used for this test:

The patient is a 65-year-old frail female with history of CVA, hypertension, and COPD. She presented after sustaining an injury to her ankle after an episode of syncope with no loss of consciousness. The patient was admitted for rule out syncope. ECG was normal and vital signs stable. She was unable to ambulate due to the injury to her ankle, which was painful and swollen. Radiogram of the ankle showed no evidence of fracture. Discharged to skilled nursing facility for physical therapy, on general cardiac diet. Follow up with primary provider 2 weeks post discharge from skilled nursing facility.

CONFORMANCE TEST TOOLS

None

Document History

Version Number	Description of Change	Date Published
0.5	Original draft version	April 9, 2010
1.0	Updated to reflect Final Rule	July 21, 2010
1.0	Updated to remove "Pending" from header	August 13, 2010