# Test Criteria: 170.315.a.6 Problem List

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| --- | --- |
| **Testing Result** |  |
| Participant and Product-with-version |  |
| Setting (Ambulatory or Inpatient) |  |
| Test Proctor |  |
| Test Date |  |
| Test Result | Pass:  Fail:  No Attempt: |
| Error Description (if applicable) |  |
| Modifications to Product Under Test |  |
| Additional Software Used |  |
| Additional Proctor Notes |  |

### Overview

In this document you will find:

* [Test Data and Test Tools](#_Test_Data_and)
* [Standards Support](#_Demonstrate_Standards_Support)
* [Drummond Test Report (Instructions, Expected Results, Points to Remember)](#_170.315(a)(6)_Problem_List)
* [Test Procedures](#_Test_Procedures)
* [Appendix A: Testing Guide](#_Appendix_A:_Testing)
* [Appendix B: ONC Criteria](#_Appendix_B:_ONC)
* [Appendix C: Problem List (a.6) Attestation Template](#_Appendix_C:_Problem)

### Version of ONC Test Method

1.0

### Scope of Proctoring Sheet

The ONC test method associated with this criterion is the only approved test method for EHR Meaningful Use certification. This Proctoring Sheet is not a replacement test method but a test procedure document for performing the ONC test method and recording the results. Proctoring Sheet describe test data, test criteria and expected results. It is assumed the Health IT Developer or Participant Under Test is familiar with the associated ONC test method.

# Robustness and Reliability Requirement

To satisfy the module criteria, it is expected that the Product-Under-Test is able to complete the testing requirements reliably, including repeat testing with the same result without error, and with a satisfactory level of robustness. This includes unexpected error messages produced through normal operation, multiple unintended restarts of the application or any other “buggy” facets of the product displayed while testing. These errors are record in the Additional Proctor Notes of the proctor sheet. Lack of reliability and robustness of design will result in failure of the module.

# Test Data and Tools

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| --- | --- |
| **Test Data Source:** | ONC-Supplied  DG-Supplied:  Developer-Supplied: |
| **Pre-Test Data Setup** *(select ambulatory or inpatient setting):*  **Ambulatory**: Health IT Developer selects a patient and pre-loads the following problems test data for:   * + **Encounter #1** (2 months before test date):   Essential Hypertension (disorder); SNOMED code: 59621000   * + **Encounter #2** (1 month before test date):   Diabetes Mellitus Type 2 (disorder)*;* SNOMED code: 44054006  **Inpatient**: Health IT Developer selects a patient and pre-loads the following problems test data for:   * + **Hospital Day #1** (2 days before test date):   Essential Hypertension (disorder); SNOMED code: 59621000   * + **Hospital Day #2** (1 day before test date):   Diabetes Mellitus Type 2 (disorder)*;* SNOMED code: 44054006 | |
| **Test Data:**  DG-supplied problems specified in test procedure below. | |
| **Test Tools:**  Not applicable. | |

# Demonstrate Standards Support

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| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** Health IT module must record problems included in the September 2015, or more recent, Release of the U.S. Edition of the SNOMED CT® standard. | |

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|  | **Problem** | **Standard** |
|  | §170.207(a)(4) | [IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release or more recent.](https://www.nlm.nih.gov/research/umls/Snomed/us_edition.html) |

# 170.315(a)(6) Problem List

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| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:**   * Record, change, and access a patient’s active problem list*.* | |
| **Expected Test Result:**   * Enable a user to electronically record, change, and, access a patient’s active problem list:  1. Ambulatory setting only. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in §170.207(a)(4). 2. Inpatient setting only. For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in §170.207(a)(4).  * Problem list data associated with SNOMED CT standard terminology are stored in the patient’s record. * User can record, change, and access active problems and problem history data correctly and without omission into the patient’s record. | |
| **Points to Remember:**   * Problems must be recorded in SNOMED CT codes. However, these codes do not necessarily have to be displayed in the user entry but can be stored or mapped elsewhere in the EHR product such as a dictionary map or a database.   If the SNOMED codes are not displayed in the user interface, then the Health IT Developer should prepare to demonstrate the codes in the data store to the Test Proctor.   * The user must record problems using different dates as illustrated in test data below. * For products certified to §170.314(a)(5) Problem List under the 2014 edition, compliance may be met through attestation. Attestation letter should confirm that the certified 2014 edition (a)(5) functionality has not changed and the product has upgraded to SNOMED CT®, U.S. Edition, September 2015 Release or a more recent version. Attestation template is available in Appendix C. | |

### Test Procedures

* 1. **Record Problem List – AMBULATORY**

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| --- | --- |
|  | User selects records containing pre-loaded problems for first two encounters or records problems as follows:  Encounter #1 – 2 Months Before Test Date:   * Essential Hypertension (disorder); SNOMED code: 59621000   Encounter #2 – 1 Month Before Test Date:   * Diabetes Mellitus Type 2 (disorder); SNOMED code: 44054006   Encounter #3 – To Be Entered on Test Date:   * Acquired Hypothyroidism (disorder): SNOMED code: 111566002 * Chronic Rejection of Renal Transplant (disorder); SNOMED code: 236578006 |

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* 1. **Record Problem List – INPATIENT**

|  |  |
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|  | User selects records containing pre-loaded problems for first two hospital days or records problems as follows:  Hospital Day #1 – 2 Days Before Test Date:   * Essential Hypertension (disorder); SNOMED code: 59621000   Hospital Day #2 – 1 Day Before Test Date:   * Diabetes Mellitus Type 2 (disorder); SNOMED code: 44054006   Hospital Day #3 – To Be Entered on Test Date:   * Acquired Hypothyroidism (disorder): SNOMED code: 111566002 * Chronic Rejection of Renal Transplant (disorder); SNOMED code: 236578006 |

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### 2.1 Change Problem List – Ambulatory and Inpatient

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| --- | --- |
|  | User changes the problems as indicated in **bold** highlight:   * Essential Hypertension (disorder)   SNOMED code: 59621000   * **RESOLVE** Diabetes Mellitus Type 2 (disorder)   SNOMED code: 44054006  **Date Changed: Encounter #3/Hospital Day #3**   * **Severe Hypothyroidism (disorder)**   **SNOMED code: 83986005**  **Date Changed: Encounter #3/Hospital Day #3**   * Chronic Rejection of Renal Transplant (disorder)   SNOMED code: 236578006 |

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### 3.1 Access Active Problem List – Ambulatory and Inpatient

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| --- | --- |
|  | User access active problem list:   * Essential Hypertension (disorder)   SNOMED code: 59621000   * Severe Hypothyroidism (disorder)   SNOMED code: 83986005   * Chronic Rejection of Renal Transplant (disorder)   SNOMED code: 236578006 |

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### 3.2 Access Problem List History – Ambulatory and Inpatient

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|  | User accesses problem list history:   * RESOLVED Diabetes Mellitus Type 2 (disorder)   SNOMED code: 44054006   * Essential Hypertension (disorder)   SNOMED code: 59621000   * Severe Hypothyroidism (disorder)   SNOMED code: 83986005   * Chronic Rejection of Renal Transplant (disorder)   SNOMED code: 236578006 |

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# Appendix A: Testing Guide

*This appendix contains more details and background on the testing requirements, including explanation on underlying standards, notable issues and best practice suggestions.*

Rev 01-Mar-2016 Additions

* Problems must be recorded in SNOMED CT codes. However, these codes do not necessarily have to be displayed in the user entry but can be stored or mapped elsewhere in the EHR product such as a dictionary map or a database.
* The test procedure is not prescriptive about the method used to modify the problem list. For example, modifying a problem list does not require modifying an existing instance of a problem. Modification can be accomplished through changing the status of an existing problem or entering a new problem.
* The syntax and categories of problem status is generally left to each implementation. It is acceptable for implementations to use different syntax and methods to identify up-to-date problems as well as historic problems. For example, “Active” problems can be identified by a different syntax such as “Current”. Also, there is no requirement that categories of “Inactive” or “Resolved” must be used for historic or non-active problems although they are common categories. However, previously diagnosed problems which are no longer active must be persisted with the patient’s record as problem history.
* The active problems and non-active problems can be contained within the same list as long as the active problems and non-active problems are clearly identified. It is also permitted that the lists be distinct.
* All status dates are to include month, day and year, but no standard date format is required.
* For EHRs designed for an ambulatory setting, access to the problem list information gathered during multiple patient visits to a single Eligible Provider shall be available to the provider. There is no requirement that problem list information gathered by other providers or hospitals be accessible in the up-to-date problem list although this information may be collected and used by application depending upon implementation.
* For EHRs designed for an inpatient care setting, access to problem list information gathered during the current hospitalization episode of care shall be available to users in the inpatient care setting. There is no requirement that problem list information gathered during prior hospitalizations or by Eligible Providers in the ambulatory settings be accessible in the up-to-date problem list although this information may be collected and used by application depending upon implementation.

# Appendix B: ONC Criteria and Standards

*This appendix contains copy of the relevant ONC criteria and standards for this proctor sheet as a reference. In the event of a discrepancy with the ONC Final Rule, the ONC Final Rule takes precedence.*

**§170.315(a)(6) *Problem list.*** Enable a user to record, change, and access a patient's active problem list:

(i) *Ambulatory setting only.* Over multiple encounters in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(4).

(ii) *Inpatient setting only.* For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(4).

**§170.207 Vocabulary standards for representing electronic health information.**

(a)(4) ***Standard.*** IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release

### Appendix C: Problem List (a)(6) Attestation Template

*This appendix contains a template for submitting 170.315(a)(6) attestation. Attestation letter should be returned on company letterhead addressing the required functionality.*

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[Name of Authorized Senior Company Representative]

[Title of Company Representative]

[Company Contact Information]

[Company Name] attests to the validity of the information below to satisfy the documentation requirements for testing and certification of the ONC 2015 Edition criteria *170.315(a)(6).*

[Product Name and version] was certified to §170.314(a)(5) Problem List under the 2014 edition. Certified functionality for this criteria has not changed with the exception of the implementation of the SNOMED CT®, U.S. Edition, September 2015 Release *(or indicate a more recent version).*

**I hereby attest that all above statements are true, as an authorized signing authority on behalf of my organization.**

[Signature]

[Signature Block of Authorized Senior Company Representative]

[Date signed]

# Change Log

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| --- | --- |
| Revision | Change Description |
| 01-Aug-2016 | Added attestation option for eligible 2014 certified products. Added Appendix C for template. |
| 01-Apr-2016 | Corrected “medications” to “problems” under section 2.1 |
| 01-Mar-2016 | Initial Release. |
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**About Drummond Group LLC**

Drummond Group LLC is a global software test and certification lab that serves a wide range of vertical industries.  In healthcare, Drummond Group tests and certifies Controlled Substance Ordering Systems (CSOS), Electronic Prescription of Controlled Substances (EPCS) software and processes, and Electronic Health Records (EHRs) – designating the trusted test lab as the only third-party certifier of all three initiatives designed to move the industry toward a digital future. Founded in 1999, and accredited for the Office of the National Coordinator Health IT Certification Program as an Authorized Certification Body (ACB) and an Authorized Test Lab (ATL), Drummond Group continues to build upon its deep experience and expertise necessary to deliver reliable and cost-effective services. For more information, please visit <http://www.drummondgroup.com> or email [ehr@drummondgroup.com](mailto:ehr@drummondgroup.com)

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