# Test Criteria: 170.315.b.6 Data Export

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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(b)(6)_Data_Export)
* [Test Procedures](#_170.315(b)(6)_Data_Export)
* [Appendix A: Testing Guide](#_Appendix_A:_Testing)
* [Appendix B: ONC Criteria](#_Appendix_B:_ONC)
* [Appendix C: CCDS Reference Table](#_Appendix_C:_)

### 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 UnderTest 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:**   * Health IT developer pre-loads the 170.315(b)(6) ONC test data available within the Edge Test Tool (ETT) based on health care setting. * Developer also supplies own patients (minimum of 5) which should be pre-loaded and sufficient for testing based on test procedure requirements below. * The ‘specific date and time’ and ‘relative date and time’ may be configured prior to test day. If opting to do so, exports should be configured to occur during the actual test day and executed according to the scheduled event. Validation of the configurations may include a screenshot from the developer if the configuration settings will not visible on test day. | |
| **Test Data:**  Test data supplied by Developer and ONC:   * Developer supplies multiple patients (minimum of 5 patients) which can be used for data export based on scheduling requirements outlined in test procedure below. * ONC-supplied test Data is downloaded for the applicable setting from the ETT [C-CDA R2.1 Validator](https://ttpedge.sitenv.org/ttp/#/validators) using the “Sender SUT Test Data” selection: * Inpatient Setting: 170.315\_b6\_de\_inp\_sample\*.pdf (All Samples) * Ambulatory Setting: 170.315\_b6\_de\_amb\_sample\*.pdf (All Samples) | |
| **Test Tools:**  Edge Test Tool (ETT) – Message Validators: [C-CDA R2.1 Validator](https://ttpedge.sitenv.org/ttp/#/validators) | |

# Demonstrate Standards Support

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| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** Implement support for standards to demonstrate compliance for data export. | |

|  |  |  |
| --- | --- | --- |
| **§170.205 Content Exchange Standards – Patient Summary Record** | | |
|  | §170.205(a)(3) | HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, DSTU Release 1.1 (US Realm) Draft Standard for Trial Use July 2012. |
|  | §170.205(a)(4) | HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 1—Introductory Material, Release 2.1 and HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 2—Templates and Supporting Material, Release 2.1 (incorporated by reference in § 170.299). |
| **§170.207 Vocabulary standards for representing electronic health information \*** | | |
|  | §170.207(a)(4) | IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release. |
|  | §170.207(b)(2) | 45 CFR 162.1002(a)(5)—combination of HCPCS and CPT-4 |
|  | §170.207(b)(3) | 45 CFR 162.1002(a)(4)—Code on Dental Procedures and Nomenclature. |
|  | §170.207(b)(4) | 45 CFR 162.1002(c)(3)—ICD-10-PCS |
|  | §170.207(c)(3) | LOINC® Database version 2.52. |
|  | §170.207(d)(3) | RxNorm, September 8, 2015 Release. |
|  | §170.207(e)(3) | HL7 CVX—Vaccines Administered, updates through August 17, 2015. |
|  | §170.207(e)(4) | National Drug Code Directory—Vaccine Codes, updates through August 17, 2015. |
|  | §170.207(f)(1) | OMB as revised, October 30, 1997. |
|  | §170.207(f)(2) | CDC Race and Ethnicity Code Set Version 1.0 (March 2000) (incorporated by reference in § 170.299). |
|  | §170.207(g)(2) | Request for Comments (RFC) 5646 (incorporated by reference in § 170.299). |
|  | §170.207(h) | Smoking status constrained codes from SNOMED CT®. |
|  | §170.207(k)(1) | LOINC® version 2.51 (minimum codes: 8480-6, 8462-4, 8302-2, 3141-9, 8867-4, 9279-1, 8310-5, 59408-5, 39156-5, and 8478-0) |
|  | §170.207(m) | Numerical references—(1) Standard. The Unified Code of Units of Measure, Revision 1.9 (incorporated by reference in § 170.299). |
|  | §170.207(n)(1) | Birth sex must be coded in accordance with HL7 Version 3 Standard, Value Sets for AdministrativeGender and NullFlavor (incorporated by reference in § 170.299), attributed as follows:  (i) Male. M (ii) Female. F  (iii) Unknown. nullFlavor UNK |

# 170.315(b)(6) Data Export

|  |  |
| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:**   * Health IT developer attests via documentation that a user can configure an export summary any time the user chooses and without subsequent developer assistance to operate. * Limit the set of users that can execute the data export function. * Demonstrate a user(s) that is not authorized to:   + Execute the data export function;   + Configure the data export timeframe parameters; and   + Configure the data export location parameter. * Authorized user configures the health IT module to export the patient summary files to a local or network location and for a specific timeframe including a relative date and time, specific date and time and “real-time”. * Authorized user generates a single data export summary, a set of export summaries for all patients, and a subset of all the patients. | |
| **Expected Test Result:**   * Enable a user to set the configuration options when creating an export summary as well as a set of export summaries for patients whose information is stored in the technology. A user must be able to execute these capabilities at any time the user chooses and without subsequent developer assistance to operate. * Limit the ability of users who can create export summaries in at least one of these two ways:  1. To a specific set of identified users 2. As a system administrative function  * Enable a user to create export summaries formatted in accordance with the standard specified in § 170.205(a)(4) using the Continuity of Care Document template that includes, at a minimum:   + - **The Common Clinical Data Set;**     - **Encounter diagnoses**. Formatted according to at least one of the following standards:       1. The standard specified in § 170.207(i)       2. At a minimum, the version of the standard specified in § 170.207(a)(4); * **Cognitive status;** * **Functional status;** * **Ambulatory setting only**. The reason for referral; and referring or transitioning provider's name and office contact information; and * **Inpatient setting only**. Discharge instructions. * Enable a user to set the date and time period within which data would be used to create the export summaries. This must include the ability to enter in a start and end date and time range. * Consistent with the date range specified above, enable a user to do each of the following:   + - * Create export summaries in real-time;       * Create export summaries based on a relative date and time (e.g., the first of every month at 1:00am); and       * Create export summaries based on a specific date and time (e.g., on 10/24/2015 at 1:00am) * Enable a user to set the storage location to which the export summary or export summaries are intended to be saved. | |
| **Points to Remember:**   * For the 2015 Edition, the user must be able to choose to create export summaries based on *one patient*, *a set of patients*, and *all patients* (“for as many patients selected”). * If the user chooses to create export summaries for *a set of patients* or *all patients*, this functionality cannot be satisfied by a user individually creating an export summary for each patient one-by-one. * Health IT Module must, at a minimum, permit a user to select a local or network storage location. * The proctor will work with the developer to use varied and applicable methods of verifying all patient summaries were exported. * DG has created a whitepaper available for download in Zendesk providing additional guidance regarding this criteria and time filter requirements. | |

**Test Procedures**

**1.1 General Requirements for Export Summary Configuration**

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| --- | --- |
|  | Health IT developer submits documentation attesting a user can configure an export summary any time the user chooses and without subsequent developer assistance to operate. |
|  | User accesses health IT module and demonstrates the ability to limit the data export function either as an administrative function or to an identified set of users. |
|  | Unauthorized user(s) attempt the following actions but is unable to:   * Execute the data export function; * Set the date/time range for an export action; * Schedule an export action either for a relative date/time or a specific date/time, and * Specify the local or network location of the exported summary file(s) |

<INSERT LINK TO DOCUMENTATION – User on-demand capability attestation>

<INSERT SCREEN SHOTS – Limited access to configure export summaries>

<INSERT SCREEN SHOTS – Unauthorized user attempts>

**1.2 Single Data Export Summary: Real-Time**

|  |  |
| --- | --- |
|  | User identifies patient records containing pre-loaded test data based on ONC-supplied “**170.315\_b6\_de\_\*\_pdf**” files and developer-supplied data. |
|  | Using health IT module functionality, user generates **a single data export summary**, in the format of a CCDA document template for each sample test case for the appropriate health care setting. |
|  | Proctor uses the Message Content Report from ETT to visually inspect each C-CDA to verify conformance and associated standards *(see “CCDS Reference Table” in* [*Appendix C*](#_Appendix_C:_) *below):*   * **The Common Clinical Data Set;** * **Encounter Diagnosis;** * **Cognitive Status;** * **Functional Status;** * *Ambulatory setting only*: **Reason for referral, referring provider name and contact info; and** * *Inpatient setting only:* **Discharge Instructions** |

<INSERT SCREEN SHOTS - Patient records>

<INSERT SCREEN SHOT – Folder/directory of generated export summaries>

<INSERT SCREEN SHOTS OR LINK TO FILE – Validation Reports>

**1.3 Export for All Patients: Real-Time**

|  |  |
| --- | --- |
|  | User configures set of export summaries **to include all patients** in health IT module by specifying an export location. |
|  | User generates **all patient summary files** including ONC test patients from ETT and developer-supplied patients *(minimum of 7 total patients including two ONC and at least five developer-supplied).* |
|  | Proctor verifies all patients in the health IT module are present in the data export summaries and files are exported to location configured above and can be saved to location specified by user. |
|  | Proctor visually inspects C-CDAs to verify conformance to the requirements and associated standards and equivalent to the information contained in the patient’s record *(see “CCDS Reference Table” below):*   * **The Common Clinical Data Set;** * **Encounter Diagnosis;** * **Cognitive Status;** * **Functional Status;** * *Ambulatory setting only*: **Reason for referral, referring provider name and contact info; and** * *Inpatient setting only:* **Discharge Instructions.** |

<INSERT SCREEN SHOT - Patient records>

<INSERT SCREEN SHOT – Folder/directory of generated export summaries>

**1.4 Export for Subset of Patients: Real-time**

|  |  |
| --- | --- |
|  | User configures set of export summaries to include a subset of patients in health IT module by specifying:   * **Export location**; * **Start and End Date** *(e.g., dates may be based on encounter, admission, etc.)* |
|  | User generates and exports a subset of patient summary files **in real-time** **based on the date range above**. |
|  | Proctor performs visual inspection of exported summaries:   * **Verifies identified subset of patient summary files** in the health IT module are present in the data export summaries; * **Section level narrative text;** * **Files are exported to location configured above and can be saved to location specified by user;** * **Export summaries cover correct time period** according to timeframe configured above; and * **Verify conformance of C-CDAs** to the requirements and associated standards and equivalent to the information contained in the patient’s record *(see “CCDS Reference Table” below):* * **The Common Clinical Data Set;** * **Encounter Diagnosis;** * **Cognitive Status;** * **Functional Status;** * *Ambulatory setting only*: **Reason for referral, referring provider name and contact info; and** * *Inpatient setting only:* **Discharge Instructions.** |

<INSERT SCREEN SHOT - Patient records>

<INSERT SCREEN SHOT – Folder/directory of generated export summaries>

**1.5 Export for Sub-Set of Patients: Schedule Specific and Relative Date and Time**

|  |  |
| --- | --- |
|  | As noted in the Pre-test Data Setup section, developer may pre-configure scheduled events for ‘specific date and time’ and ‘relative date and time’ and provide screenshot to Proctor. Otherwise, follow steps below. |
|  | User configures set of export summaries to include a subset of patients in health IT module by specifying:   * **Export location**; and * **Start and End Date** *(e.g., dates may be based on encounter, admission, etc.)* |
|  | User generates a subset of patient summary files scheduled for export on a **specific date and time** *(e.g. on April 1, 2017 at 1:00AM EDT).* |
|  | User generates a subset of patient summary files scheduled for export at a **relative date and time** *(e.g. on the first of every month at midnight).* |
|  | Proctor performs visual inspection of exported summaries:   * **Verifies identified subset of patient summary files** in the health IT module are present in the data export summaries; * **Section level narrative text;** * **Files are exported to location configured above and can be saved to location specified by user;** * **Export summaries cover correct time period** according to timeframe configured above; and * **Verify conformance of C-CDAs** to the requirements and associated standards and equivalent to the information contained in the patient’s record *(see “CCDS Reference Table” below):* * **The Common Clinical Data Set;** * **Encounter Diagnosis;** * **Cognitive Status;** * **Functional Status;** * *Ambulatory setting only*: **Reason for referral, referring provider name and contact info;** and * *Inpatient setting only:* **Discharge Instructions.** |

<INSERT SCREEN SHOT – Configurations settings for Specific Date and Time>

<INSERT SCREEN SHOT – Folder/directory of generated export summaries>

<INSERT SCREEN SHOT – Configurations settings for Relative Date and Time>

<INSERT SCREEN SHOT – Folder/directory of generated export summaries>

# 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 03-Jan-2017 Additions

* The selection of summaries to be selected and exported is essentially three-fold:

1. An “on demand” and “one-time” export done at that time for all summaries which fall within a start and end date. For example, immediate export for all patients which have an encounter visit from June 1, 2016 to June 15, 2016.
2. A “schedule” and “one-time” export done at a time in the future for all summaries which fall within a start and end date. For example, schedule export done tomorrow at 12:30 AM for all summaries records with for patients with encounter visits from June 1, 2016 to June 15, 2016.
3. A “reoccurring” export done on regular basis for summaries which fall within a relative time period. For example, schedule export of summaries records for all patients with encounters from the prior month on the 1st Tuesday of the month at 12:30 AM.

*Note: The above examples used encounter date as method for date-time filtering. It was presented merely as an example, but other methods are permissible.*

Rev 01-Mar-2016 Additions

* A user needs to be able to:
  1. Create an export summary or export summaries in real-time (i.e., on demand);
  2. Configure technology to create such summaries based on a relative date and time *(e.g., generate a set of export summaries from the prior month on the first of every month);* and
  3. Configure technology to create such summaries based on a specific date and time *(e.g., generate a set of export summaries with a date range between January 1, 2015 and March 31, 2015 on April 1, 2015 at 1:00AM EDT).*
* §170.314(b)(7) “data portability” is now named § 170.315(b)(6) “data export”. To provide additional clarity of the criterion concept, we have decided to name the adopted certification criterion “data export.”
* To demonstrate compliance with this certification criterion, health IT module must “enable a user to electronically create a set of export summaries for all patients in health IT module formatted according to the C-CDA. For the 2015 Edition, the user must be able to choose to create export summaries for one patient, a set of patients, or all patients (“for as many patients selected”).

If the user chooses to create export summaries for a set of patients or all patients, this functionality cannot be satisfied by a user individually creating an export summary for each patient one-by-one.

* This certification criterion requires conformance to the C-CDA R2.1, limited to the C-CDA document template. The vocabularies used by the C-CDA R2.1 are adopt as published, with the proposed inclusion of the Common Clinical Data Set and other specified data.
* Procedures and lab tests are both required to be coded with respective standards. “Lab tests”, if referred to as “future scheduled tests” needed to be coded. The HL7 C-CDA companion guide suggests that future scheduled tests belong in the Plan of Care section and that is how/what the CCDA validator is built to follow. Thus, coded entries for future procedures and lab tests need to be in the Plan of Care section.
* A user must be able to express a start and end date range to meet this requirement.
* The provision that “limits” functionality on the type of users that may execute the data export functionality is intended to be used by and at the discretion of the provider organization implementing the technology. In other words, this functionality cannot be used by health IT developers as an implicit way to thwart or moot the overarching user driven aspect of this certification criterion.
* This certification criterion’s purpose is to enable a user to export clinical data from health IT for one patient, a set of patients, or a subset of that set of patients. The functionality included in the criterion is intended to support a range of uses determined by a user and it was not our intention to prescribe or imply particular uses for this functionality. We also note that this functionality is not intended to and may not be sufficient to accomplish a full migration from one product to another without additional intervention because of the scope of this criterion. Specifically, the data and document templates specified in this criterion would not likely support a full migration, which could include administrative data such as billing information. The criterion’s functionality could, however, support the migration of clinical data between health IT systems and can play a role in expediting such an activity if so determined by the user.
* Consistent with other responses provided in this final rule, this certification criterion requires conformance to the C-CDA R2.1. In consideration of comments received on the Proposed Rule, we have limited the C-CDA document template scope for this criterion to the CCD document template. We note that the vocabularies used by the C-CDA R2.1 are defined through the Standards Developing Organization (SDO) process and we do not seek to change that approach via this rulemaking (i.e., we adopt the C-CDA R2.1 as published). We note that we have adopted this criterion with the proposed inclusion of the Common Clinical Data Set and other specified data.
* A Health IT Module must, at a minimum, permit a user to select a local or network storage location. The specific transport method (e.g., sending to a Direct email address) or further product integration (e.g., routing the export to a web service, web service or integration engine) is left to the discretion of the health IT developer and its customers.

# 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(b)(6) Data export**

* 1. General requirements for export summary configuration.
     1. Enable a user to set the configuration options specified in paragraph (b)(6)(ii) through (iv) of this section when creating an export summary as well as a set of export summaries for patients whose information is stored in the technology. A user must be able to execute these capabilities at any time the user chooses and without subsequent developer assistance to operate.
     2. Limit the ability of users who can create export summaries in at least one of these two ways:
        1. To a specific set of identified users.
        2. As a system administrative function.
  2. Creation configuration. Enable a user to configure the technology to create export summaries formatted in accordance with the standard specified at §170.205(a)(4) using the Continuity of Care Document document template that includes, at a minimum:
     1. The Common Clinical Data Set.
     2. Encounter diagnoses. Formatted according to at least one of the following standard:
        1. The standard specified in §170.207(i).
        2. At a minimum, the version of the standard specified in §170.207(a)(4).
     3. Cognitive status.
     4. Functional status.
     5. Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information.
     6. Inpatient setting only. Discharge instructions.
  3. Timeframe configuration.
     1. Enable a user to set the date and time period within which data would be used to create the export summaries. This must include the ability to enter in a start and end date and time range.
     2. Consistent with the date and time period specified in paragraph (b)(6)(iii)(A) of this section, enable a user to do each of the following:
        1. Create export summaries in real-time;
        2. Create export summaries based on a relative date and time (e.g., the first of every month at 1:00am); and
        3. Create export summaries based on a specific date and time (e.g., on 10/24/2015 at 1:00am).
  4. Location configuration. Enable a user to set the storage location to which the export summary or export summaries are intended to be saved.

**§170.205 Content exchange standards and implementation specifications for exchanging health information**

(a)(4) Standard. HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 1 – Introductory Material, Release 2.1 and HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use, Volume 2 – Templates and Supporting Material, Release 2.1.

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

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

(i) The code set specified at 45 CFR 162.1002(c)(2) for the indicated conditions. International Classification of Diseases, 10th Revision, Clinical Modification

(ICD–10–CM) (including The Official ICD–10–CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions:

(i) Diseases.

(ii) Injuries.

(iii) Impairments.

(iv) Other health problems and their manifestations.

(v) Causes of injury, disease, impairment, or other health problems

# Appendix C: CCDS Reference Table

# *This appendix contains a reference guide to evaluate the Common Clinical Data Set, Diagnostic Image Report, Laboratory Test Result, and additional elements are populated accurately and without omission.*

**CCDS Reference Table**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Test Data** | **CCDS** | **Standard** |
|  |  | Patient Name | **<Not applicable>** |
|  |  | Sex; including Birth sex | **§170.207 (n)(1)** |
|  |  | Date of Birth | **<Not applicable>** |
|  |  | Race | **§170.207(f)(2)** mapped to **§170.207(f)(1); §170.207 (f)(2)** |
|  |  | Ethnicity | **§170.207(f)(1)** mapped to **§170.207(f)(1); §170.207 (f)(2)** |
|  |  | Preferred Language | **§170.207 (g)(2)** |
|  |  | Smoking Status | **§170.207 (h)** |
|  |  | Problems | **§170.207 (a)(4)** |
|  |  | Medications | **§170.207 (d)(3)** |
|  |  | Allergies | **§170.207 (d)(3)** |
|  |  | Lab Tests | **§170.207 (m)(1)** |
|  |  | Lab Values(s)/Results | **<Not applicable>** |
|  |  | Vital Signs | **§170.207 (k)(1), §170.207 (m)(1)** |
|  |  | BMI (Optional) | **§170.207 (c)(3), §170.207 (m)(1)** |
|  |  | BMI (Optional) |  |
|  |  | Procedures | **§170.207 (a)(4)**  **§170.207 (b)(2)** |
|  |  | Procedures (Optional: for dental systems) | **§170.207 (b)(3)** |
|  |  | Procedures (Optional) | **§170.207 (b)(4)** |
|  |  | Care Team Member(s) | **<Not applicable>** |
|  |  | Immunizations | **§170.207 (e)(3), §170.207 (e)(4)** |
|  |  | Unique Device Identifier(s) for a Patient’s Implantable Device(s) | **“Product Instance” in the “Procedure Activity Procedure Section” of the standard specified in § 170.205(a)(4)** |
|  |  | Assessment and Plan of Treatment | **In accordance with the “Assessment and Plan Section (V2)” of the standard specified in § 170.205(a)(4); or**  **In accordance with the “Assessment Section (V2)” and “Plan of Treatment Section (V2)” of the standard specified in § 170.205(a)(4).** |
|  |  | Goals | **Goals Section” of the standard specified in § 170.205(a)(4) for certification to the 2015 Edition health IT certification criteria.** |
|  |  | Health Concerns | **In accordance with the “Health Concerns Section” of the standard specified in § 170.205(a)(4) for certification to the 2015 Edition health IT certification criteria.** |
|  | **Test Data** | **Data Element** | **Standard** |
|  |  | Encounter diagnoses | **§170.207 (i) or §170.207 (a)(4)** |
|  |  | Cognitive Status | **<Not applicable>** |
|  |  | Functional Status | **<Not applicable>** |
| **AMBULATORY ONLY** | | | |
|  | **Test Data** | **Data Element** | **Standard** |
|  |  | Reason for referral | **<Not applicable>** |
|  |  | Referring or transitioning provider’s name and office contact information | **<Not applicable>** |
| **INPATIENT ONLY** | | | |
|  | **Test Data** | **Data Element** | **Standard** |
|  |  | Discharge Instructions | **<Not applicable>** |
|  |  | Patient matching | **§170.207 (f)(1)** mapped to **§170.207(f)(2);**  **§170.207 (f)(2)** |

# Change Log

|  |  |
| --- | --- |
| Revision | Change Description |
| 03-Jan-2017 | Added option to configure specific and relative date/time prior to test event under Pre-test Data Setup section. Clarified date and time required under section 1.5. Removed real-time export from section 1.1. Added Rev 03-Jan-2017 additions under Appendix A. |
| 01-Oct-2016 | Updated hyperlinks for ONC-hosted ETT. Added CCDS Reference table under Appendix C. Consolidated section 1.3 into 1.2 and renumbered remaining sections. |
| 01-Aug-2016 | Corrected Pretest Data Setup from (b)(4) to (b)(6). Replaced AND with OR under “Points to Remember” clarifying user must be able to export one patient, set of patients *AND* all patients. Developer-supplied test data updated to indicate a minimum of 5 test patients required. |
| 01-May-2016 | Corrected Race and Ethnicity entries on “CCDS Reference Table” to clarify 170.207(f)(2) should be mapped to 170.207(f)(1). |
| 01-Mar-2016 | Initial Release. |
|  |  |
|  |  |

**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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