# Test Criteria: 170.315.e.3 – Patient Health Information Capture

|  |  |
| --- | --- |
| **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(e)(3)_–_Patient)
* [Test Procedures](#_1.1_Patient_Health)
* [Appendix A: Testing Guide](#_Appendix_A:_Testing)
* [Appendix B: ONC Criteria](#_Appendix_B:_ONC)

### 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

|  |  |
| --- | --- |
| **Test Data Source:** | ONC-Supplied  DG-Supplied:  Developer-Supplied: |
| **Pre-Test Data Setup:**  Health IT developer prepares patient health document to be used during testing. | |
| **Test Data:**  Developer-supplied. | |
| **Test Tools:**  Not applicable. | |

# Demonstrate Standards Support

|  |  |
| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** Not applicable. | |

# 170.315(e)(3) – Patient Health Information Capture

|  |  |
| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** Identify, record, and access patient health information. | |
| **Expected Test Result:**   * Health IT module (HIT) must enable a user to identify, record, and access information directly and electronically shared by a patient (or authorized representative). | |
| **Points to Remember:**   * Lack of specificity encourages Health IT developers to develop innovative and efficient ways to meet this criterion and simultaneously support providers accepting health information from patients. | |

**Test Procedures**

### 1.1 Patient Health Information Capture

|  |  |
| --- | --- |
|  | Health IT Developer identifies method for patient and authorized representative to directly and electronically share health information. |
|  | User #1 logs in and identifies, or labels, the health information directly and electronically shared by patient. |
|  | User #1 records health information directly and electronically shared by patient and associates it with the specific patient record along with information identifier. |
|  | User #1 accesses health information directly and electronically shared by patient. |
|  | User #1 demonstrates the ability to link to an external internet site where patient health information document is stored. |
|  | User #1 creates a reference to the linked patient health information document. |

<INSERT SCREEN SHOTS>

# 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

* The intent of this provision is to establish at least one means for accepting patient health information directly and electronically from patients in the most flexible manner possible.
* The criterion does not seek to define the types of health information that could be accepted as we believe this should be as broad as possible and could be documents or health information from devices or applications. The devices and applications could include home health or personal health monitoring devices, fitness and nutrition applications, or a variety of other devices and applications. In addition, patient health information could be accepted directly and electronically through a patient portal, an API, or even email.
* “Identify,” by example, means labeling health information documents as “advance directives” or “birth plans.”
* Record means the ability to capture and store.
* Access means the ability to examine and review.
* “Reference” requires providing narrative information on where to locate a specific health information document.
* “Linking” requires a Health IT Module to demonstrate it could link to an external internet site storing a health information document. While an intranet link to a health information document might suffice for provider use, a Health IT Module will still need to demonstrate the ability to link to an external site via the internet for the purposes of certification. The requirement of this provision does not go beyond this specified functionality.

# 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(e)(3) Patient health information capture.**

Technology must be able to enable a user to:

1. Identify, record, and access patient health information documents;
2. Reference and link to patient health information documents; and
3. Record and access information directly shared by a patient.

# Change Log

|  |  |
| --- | --- |
| Revision | Change Description |
| 01-Mar-2016 | Initial Release. |
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**About Drummond Group LLC**

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