# Test Criteria: 170.315.b.4 Common Clinical Data Set Summary Record – Create

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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(i)_Common_Clinical)
* [Test Procedures](#_Test_Procedures)
* [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 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)(4) ONC test data specified below based on health care setting. | |
| **Test Data:**  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\_b4\_CCDS\_Inp” (All Samples)   + Ambulatory Setting: “170.315\_b4\_CCDS\_Amb” (All Samples) | |
| **Test Tools:**  Edge Test Tool – 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 creating summary care records. | |

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| **§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](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=258) |
|  | §170.205(a)(4) | [HL7 Implementation Guide for CDA Release 2 Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use Release 2.1, August 2015](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=379) |
| **§170.207 Vocabulary standards for representing electronic health information \*** | | |
|  | §170.207(a)(4) | [IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release](https://www.nlm.nih.gov/healthit/snomedct/us_edition.html) |
|  | §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 |
| **§170.210 Standards for health information technology to protect electronic health information created, maintained, and exchanged.** | | |
|  | §170.210(g) | Synchronized clocks. The date and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, (incorporated by reference in §170.299) or (RFC 5905) Network Time Protocol Version 4, (incorporated by reference in §170.299). |

# 170.315(i) Common Clinical Data Set Summary Record - Create

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| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** Health IT developer generates the required C-CDA R2.1 documents based on the setting being tested for certification. | |
| **Expected Test Result:**   * Enable a user to create a transition of care/referral summary formatted in accordance with the standards specified in § 170.205(a)(4) using the Continuity of Care Document, Referral Note, and (for inpatient setting only) Discharge Summary document templates that includes at a minimum: * **The Common Clinical Data Set;** * **Encounter diagnoses**. Formatted according to at least one of the following standards: the standard specified in §170.207(i) or 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 * **Inpatient setting only**. Discharge instructions; and * **Patient matching data**. First name, last name, previous name, middle name (including middle initial), suffix, date of birth, address, phone number, and sex. The following constraints apply:   (A) Date of birth constraint—   * 1. The year, month and date of birth must be present for a date of birth. The technology must include a null value when the date of birth is unknown.   2. Optional. When the hour, minute and second are associated with a date of birth the technology must demonstrate that the correct time zone offset is included.   (B) Phone number constraint. Represent phone number (home, business, cell) in accordance with the standards adopted in § 170.207(q)(1). All phone numbers must be included when multiple phone numbers are present.  (C) Sex constraint. Represent sex in accordance with the standard adopted in § 170.207(n)(1).   * User creates documents formatted in accordance with the C-CDA R2.1 standard. * Each required C-CDA document passes the ETT validation and the Test Proctor’s visual inspection for C-CDA R2.1 template, vocabulary, and section narrative text conformance. * All required CCDS information is populated and valid. * Visual inspection of C-CDA R2.1 template, vocabulary, and section narrative text conformance. | |
| **Points to Remember:**   * The submission of a CCDS summary record document is required for all of the CCDS summary record instruction documents for a given health IT setting. | |

### Test Procedures

* 1. **CCDS Summary Record – Create**

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| --- | --- |
|  | Health IT developer identifies patient records containing pre-loaded test data based on “**170.315\_b4\_ccds\_create\*sample\*.pdf**” files. |
|  | Proctor verifies CCDS Summary Record information recorded is accurate and without omission. |

<INSERT SCREEN SHOTS - Patient records>

|  |  |
| --- | --- |
|  | User generates the required CCDA document templates using HIT module functionality for each sample test case for the appropriate health care setting:   * **Continuity of Care Document;** * **C-CDA R2 R2.1 Referral Note Document; and** * *Inpatient setting only:*  **C-CDA R2 R2.1** **Discharge Summary** |

<INSERT SCREEN SHOT – Continuity of Care Generated>

<INSERT SCREEN SHOT – Referral Note Generated>

<INSERT SCREEN SHOT – Discharge Summary Generated – Inpatient Only>

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|  | Proctor validates each C-CDA document using the Edge Test Tool [C-CDA R2.1 Validator](https://ttpedge.sitenv.org/ttp/#/validators). All files should pass without error to confirm CCDS summary record(s) is compliant. |

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

**1.2 Visual Inspection**

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|  | Using the ONC-supplied *CCDS summary record instructions* and the *Message Content Report produced by the ETT: Message Validators*, Proctor verifies the additional checks for equivalent text for the content of all section level narrative text. |
|  | Proctor visually inspects each C-CDA to verify it is conformant 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;** * *Inpatient setting only:* **Discharge Instructions; and** * **Patient Matching Data.** |

<INSERT SCREEN SHOTS>

**CCDS Reference Table**

[2015 Common Clinical Data Set](https://www.healthit.gov/sites/default/files/2015Ed_CCG_CCDS.pdf)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **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)(2)** 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)** |
|  |  | 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)** |
| **PATIENT MATCHING** | | | |
|  | **Test Data** | **Data Element** | **Standard** |
|  |  | First name |  |
|  |  | Last name |  |
|  |  | Previous name |  |
|  |  | Middle name (including middle initial) |  |
|  |  | Suffix |  |
|  |  | Date of birth | **(i)The year, month and day of birth must be present for a date of birth The technology must include a null value when the date of birth is unknown.**  **(i) Optional: When the hour, minute and second are associated with a date of birth the technology must demonstrate that the correct time zone offset is included.** |
|  |  | Address |  |
|  |  | Phone number | **Represent phone number (home, business, cell) in accordance with the standards adopted in § 170.207(q)(1). All phone numbers must be included when multiple phone numbers are present.** |
|  |  | Sex | **Represent sex in accordance with the standard adopted in § 170.207(n)(1), birth sex coded in accordance with HL7 v3 value sets for AdministrativeGender and Nullflavor attributed as follows:**   1. **Male M;** 2. **Female F;** 3. **Unknown. nullFlavor UNK** |

# 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 scope of this criterion is limited to the Consolidated CDA (C-CDA) Continuity of Care Document (CCD), Referral Note, and (for the inpatient setting only) Discharge Summary document templates.
* We recommend health IT developers and providers follow the guidance provided in the [HL7 Implementation Guide: S&I Framework Transitions of Care Companion Guide to Consolidated-CDA for Meaningful Use Stage 2, Release 1 – US Realm](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=374). This Companion Guide includes industry best practices guidance for consistent implementation of the CCDA Release 1.1 standard, including mapping Common MU Data Set elements into the C-CDA standard. We understand that HL7 is developing a Companion Guide for C-CDA Release 2.1 and intend to update this document once it becomes publicly available. In the meantime, we recommend developers follow the guidance provided by the HL7 CDA Example Task Force for implementation of the CCDA Release 2.1 standard.
* In order to facilitate the translation of SNOMED CT® codes to ICD-10-CM in administrative systems, developers are encouraged to reference the publicly available mapping that the National Library of Medicine provides.
* Health IT Modules can present for certification to a more recent version of SNOMED CT®, U.S. Edition than the September 2015 Release per ONC’s policy that permits certification to a more recent version of certain vocabulary standards.
* The C-CDA Cognitive Status Observation template has been deprecated in Release 2.1 and has been replaced with the Mental Status Observation template. Developers should use the Mental Status Observation template for cognitive status and be aware that the CCDA validator will issue an error if the deprecated Cognitive Status Observation is used instead.

# 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)(4) *Common Clinical Data summary record - create.*** Enable a user to create a transition of care/referral summary formatted in accordance with the standards specified in § 170.205(a)(4) using the Continuity of Care Document, Referral Note, and (for inpatient setting only) Discharge Summary document templates that includes at a minimum:

The Common Clinical Data Set.

Encounter diagnoses. Formatted according to at least one of the following standards:

(A) The standard specified in § 170.207(i) or 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

Inpatient setting only. Discharge instructions.

Patient matching data. First name, last name, previous name, middle name (including middle initial), suffix, date of birth, address, phone number, and sex. The following constraints apply:

(A) Date of birth constraint— (1) The year, month and date of birth must be present for a date of birth. The technology must include a null value when the date of birth is unknown. (2) Optional. When the hour, minute and second are associated with a date of birth the technology must demonstrate that the correct time zone offset is included.

(B) Phone number constraint. Represent phone number (home, business, cell) in accordance with the standards adopted in § 170.207(q)(1). All phone numbers must be included when multiple phone numbers are present.

(C) Sex constraint. Represent sex in accordance with the standard adopted in § 170.207(n)(1).

**§170.102 – Definitions**

***Common Clinical Data Set*** means the following data expressed, where indicated, according to the specified standard(s):

(1) *Patient name.*

(2) *Sex.* (ii) The standard specified in § 170.207(n)(1).

(3) *Date of birth.*

(4) *Race.* (ii) For certification to the 2015 Edition health IT certification criteria:

(A) The standard specified in § 170.207(f)(2);

(B) The standard specified in § 170.207(f)(1) for each race identified in accordance § 170.207(f)(2).

(5) *Ethnicity.* (ii) For certification to the 2015 Edition health IT certification criteria:

(A) The standard specified in § 170.207(f)(2);

(B) The standard specified in § 170.207(f)(1) for each ethnicity identified in accordance § 170.207(f)(2).

(6) *Preferred language.* (ii) The standard specified in § 170.207(g)(2).

(7) *Smoking status.* The standard specified in § 170.207(h).

(8) *Problems.* (ii) At a minimum, the standard specified in § 170.207(a)(4).

(9) *Medications.* (ii) At a minimum, the standard specified in § 170.207(d)(3).

(10) *Medication allergies.* (ii) At a minimum, the standard specified in § 170.207(d)(3).

(11) *Laboratory test(s).* (ii) At a minimum, the standard specified in § 170.207(c)(3).

(12) *Laboratory value(s)/result(s).*

(13) *Vital signs.* (ii) For certification to the 2015 Edition Health IT certification criteria:

(A) The patient's diastolic blood pressure, systolic blood pressure, body height, body weight, heart rate, respiratory rate, body temperature, pulse oximetry, and inhaled oxygen concentration must be exchanged in numerical values only; and

(B) In accordance with the standard specified in § 170.207(c)(3) and with the associated applicable unit of measure for the vital sign measurement in the standard specified in § 170.207(m)(1).

(C) *Optional.* The patient's BMI percentile per age and sex for youth 2-20 years of age, weight for age per length and sex for children less than 3 years of age, and head occipital-frontal circumference for children less than 3 years of age must be recorded in numerical values only in accordance with the standard specified in § 170.207(c)(3) and with the associated applicable unit of measure for the vital sign measurement in the standard specified in § 170.207(m)(1). For BMI percentile per age and sex for youth 2-20 years of age and weight for age per length and sex for children less than 3 years of age, the reference range/scale or growth curve should be included as appropriate.

(15) *Procedures*—(i)(A) At a minimum, the version of the standard specified in § 170.207(a)(4), or § 170.207(b)(2); or

(B) For technology primarily developed to record dental procedures, the standard specified in § 170.207(b)(3).

(ii) *Optional.* The standard specified in § 170.207(b)(4).

(16) *Care team member(s).*

(17) *Immunizations.* In accordance with, at a minimum, the standards specified in § 170.207(e)(3) and (4).

(18) *Unique device identifier(s) for a patient's implantable device(s).* In accordance with the “Product Instance” in the “Procedure Activity Procedure Section” of the standard specified in § 170.205(a)(4).

(19) *Assessment and plan of treatment.* (i) In accordance with the “Assessment and Plan Section (V2)” of the standard specified in § 170.205(a)(4); or

(ii) In accordance with the “Assessment Section (V2)” and “Plan of Treatment Section (V2)” of the standard specified in § 170.205(a)(4).

(20) *Goals.* In accordance with the “Goals Section” of the standard specified in § 170.205(a)(4).

(21) *Health concerns.* In accordance with the “Health Concerns Section” of the standard specified in § 170.205(a)(4).

**§170.205 Content Exchange Standards – Patient Summary Record.**

**(a)(3) *Standard.*** HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, DSTU Release 1.1 (US Realm) Draft Standard for Trial Use July 2012.

**(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 (incorporated by reference in § 170.299).

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

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

**(b)(2) *Standard*.** 45 CFR 162.1002(a)(5)—combination of HCPCS and CPT-4

**(b)(3) *Standard.*** 45 CFR 162.1002(a)(4)—Code on Dental Procedures and Nomenclature.

**(b)(4) *Standard.*** 45 CFR 162.1002(c)(3)—ICD-10-PCS

**(c)(3) *Standard.*** LOINC® Database version 2.52.

**(d)(3) *Standard.*** RxNorm, September 8, 2015 Release.

**(e)(3) *Standard.*** HL7 CVX—Vaccines Administered, updates through August 17, 2015.

**(e)(4) *Standard.*** National Drug Code Directory—Vaccine Codes, updates through August 17, 2015.

**(f)(1) *Standard.*** OMB as revised, October 30, 1997.

**(f)(2) *Standard.*** CDC Race and Ethnicity Code Set Version 1.0 (March 2000) (incorporated by reference in § 170.299).

**(g)(2) *Standard.*** Request for Comments (RFC) 5646 (incorporated by reference in § 170.299).

**(h) *Standard.*** Smoking status constrained codes from SNOMED CT®.

**(k)(1) *Standard.*** 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)

***(m) Numerical references—(1) Standard.*** The Unified Code of Units of Measure, Revision 1.9 (incorporated by reference in § 170.299).

**(n)(1) *Standard*.** 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

**§170.210 Standards for health information technology to protect electronic health information created, maintained, and exchanged.**

(g) Synchronized clocks. The date and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, (incorporated by reference in §170.299) or (RFC 5905) Network Time Protocol Version 4, (incorporated by reference in §170.299).

# Change Log

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| --- | --- |
| Revision | Change Description |
| 01-Oct-2016 | Updated hyperlinks for ONC-hosted ETT. Updated ETT test data filenames. |
| 01-Jun-2016 | Added hyperlinks to standards list. |
| 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. |
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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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