# Test Criteria: 170.315.f.5– Transmission to Public Health Agencies – Electronic Case Reporting

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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(f)(6)-Transmission_to_Publi)
* [Test Procedures](#_1.1_Create_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

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| --- | --- |
| **Test Data Source:** | ONC-Supplied  DG-Supplied:  Developer-Supplied: |
| **Pre-Test Data Setup:**  Prepare a test patient and ‘matched’ reportable condition trigger code (RCTC) in order to create an electronic case report. | |
| **Test Data:**  Developer-supplied. | |
| **Test Tools:**  None. | |

# Demonstrate Standards Support

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| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** Implement standards below for health care surveys content. For additional references, click [here](https://www.healthit.gov/policy-researchers-implementers/meaningful-use-stage-2-0/standards-hub) for the ONC Standards Hub. | |

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| --- | --- | --- |
|  | **Standard** |  |
|  | §170.207(i) | [ICD-10-CM](https://www.cms.gov/Medicare/Coding/ICD10/index.html) |
|  | §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(f)(5)-Transmission to Public Health – Electronic Case Reporting

|  |  |
| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** Consume and maintain a table of trigger codes to determine which encounters should initiate and initial case report being sent to a public health agency. | |
| **Expected Test Result:**   * Health IT developer must demonstrate via documentation that the health IT module has the ability to:   + consume and maintain a table of trigger codes to determine which encounters may be reportable;   + match one or more patient visits or encounters to the parameters of the trigger code table; and   + create a case report for the patient encounter(s) based on a matched trigger. | |
| **Points to Remember:**   * A specific content exchange standard for electronic case reporting (eCR) is not required to meet this criterion. * The requirement for an identifier representing the row and version of the trigger table that triggered the case report in (iii) (B) can be met by providing an identifier that will uniquely identify the original file from which the “matched trigger” described above originated (the version of the trigger table) as well as uniquely identify the individual trigger (row) itself. * An example of the Reportable Conditions Trigger Codes (RCTC) is available on the [ONC CCG (f.5) page](https://www.healthit.gov/sites/default/files/2015Ed_CCG_f5-Trans-PHA-case-reporting.pdf). | |

**Test Procedures**

### 1.1 Consume and Maintain Table of Reportable Condition Trigger Codes (RCTC)

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| --- | --- |
|  | Health IT developer submits documentation for one of the following:  **1).** Documentation that sufficiently describes how the health IT module meets the functional requirements of the criterion including how the health IT module:   * can consume a table of trigger codes that will be used to determine which encounters should initiate an initial case report being sent to public health; * is able to maintain updates to a table of trigger codes; * correctly match a patient encounter or visit based on the parameters of the trigger code table; and   + can create a case report for the patient encounter(s) based on a matched trigger and describing set of data elements used for the report (as detailed in section 1.2 below).   **2).** Documentation of participation in an initial eCR implementation as part of the [Digital Bridge initiative](http://www.digitalbridge.us/) and the ability to consume and maintain a table of trigger codes to determine encounters to initiate an initial case report being sent to a public health agency. |

<INSERT LINK TO DOCUMENTATION>

### 1.2 Case Report Creation

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| --- | --- |
|  | Health IT developer supplies test data in order to create a case report based on a matched trigger. |
|  | Proctor visually inspects to verify the case report includes:   * Encounter diagnoses using either ICD-10 or SNOMED; * The provider's name, office contact information, and reason for visit; * An identifier representing the row and version of the trigger table; * The following elements from the [Common Clinical Data Set](https://www.healthit.gov/sites/default/files/2015Ed_CCG_CCDS.pdf) should be included:   + Patient Name   + Sex   + Date of Birth   + Race and Ethnicity   + Preferred language   + Problems   + Medications   + Laboratory Tests   + Laboratory Values(s)/Result(s)   + Vital Signs   + Procedures   + Care Team Member(s)   + Immunizations   + Assessment and Plan of Treatment |

<INSERT LINK TO DOCUMENTATION>

# 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.*

None.

# 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(f)(7) Transmission to Public Health Agencies – Health Care Surveys**

Transmission to public health agencies – electronic case reporting.

1. Consume and maintain a table of trigger codes to determine which encounters may be reportable.
2. Match a patient visit or encounter to the trigger code based on the parameters of the trigger code table.
3. Case report creation. Create a case report for electronic transmission.
   1. Based on a matched trigger from paragraph (ii).
   2. That includes, at a minimum:
      1. The Common Clinical Data Set.
      2. 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).
      3. The provider's name, office contact information, and reason for visit.
      4. An identifier representing the row and version of the trigger table that triggered the case report.

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

# Change Log

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| --- | --- |
| Revision | Change Description |
| 15-Sept-2017 | Initial Release. |
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**About Drummond Group LLC**

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