# Test Criteria: 170.315.a.12 Family Health History

|  |  |
| --- | --- |
| **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)(12)_Family_Health)
* [Test Procedures](#_Test_Procedures)
* [Appendix A: Testing Guide](#_Appendix_A:_Testing)
* [Appendix B: ONC Criteria](#_Appendix_B:_ONC)
* [Appendix C: Family History (a)(12) Attestation Template](#_Appendix_C:_Family)

### 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:**  Not applicable. | |
| **Test Data:**  Developer-supplied. | |
| **Test Tools:**  Not applicable | |

# Demonstrate Standards Support

|  |  |
| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt:  Not Applicable: |
| **Instructions:** Health IT module must use familial concepts or expressions included in the September 2015, or more recent, Release of the U.S. Edition of the SNOMED CT® standard. | |

|  |  |  |
| --- | --- | --- |
|  | **Family Health History** | **Standard** |
|  | §170.207(a)(4) | IHTSDO SNOMED CT®, U.S. Edition, September 2015 Release or more recent. |

# 170.315(a)(12) Family Health History

|  |  |
| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** The user records, changes, and accesses family health history for first-degree family members as structured data. At a minimum, this includes at least one parent, one child and one sibling*.* | |
| **Expected Test Result:**   * The user can record, change, and access a patient’s family health history in accordance with the standard specified at §170.207(a)(4). * Family health history data is recorded, changed, and accessed correctly and without omission. | |
| **Points to Remember:**   * For testing and certification, at a minimum, a system should be able to demonstrate that it can record, change, and access the diagnosis using a SNOMED CT® code. * 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. * For products certified to §170.314(a)(12) Family Health History 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. **Family Health History - Record**

|  |  |
| --- | --- |
|  | User selects a patient record and records family health history (diagnosis) associated with first-degree family members:   * Parent * Child * Sibling |

<INSERT SCREEN SHOTS>

* 1. **Family Health History - Change**

|  |  |
| --- | --- |
|  | User changes family health history for first-degree family members. Change must include changing family health (diagnosis) vocabulary codes associated with at least one parent, child, and sibling. |

<INSERT SCREEN SHOTS>

* 1. **Family Health History - Access**

|  |  |
| --- | --- |
|  | User accesses patient record and displays family health history entered above. |

<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

* Family history is for a first degree relative which is a family member who shares about 50 percent of their genes with a particular individual in a family (includes parents, offspring and siblings).
* It is entirely up to the developer how the system will represent the familial relationship. For example, the familial relationship can be represented using the pre-coordinated SNOMED CT® codes that link both a relationship with a diagnosis or the developer may choose another method for coding the familial relationship (e.g., HL7 Pedigree).

# 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)(12) *Family health history.*** Enable a user to record, change, and access a patient's family health history in accordance with the familial concepts or expressions included in, at a minimum, the version of the standard 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: Family History (a)(12) Attestation Template

*This appendix contains a template for submitting 170.315(a)(12) 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)(12).*

[Product Name and version] was certified to §170.314(a)(13) Family Health History 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

|  |  |
| --- | --- |
| Revision | Change Description |
| 01-Nov-2016 | Divided each action (record, change, access) to its own section. |
| 01-Aug-2016 | Added attestation option for eligible 2014 certified products. Added Appendix C for template. |
| 01-Mar-2016 | Initial Release. |
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**About Drummond Group LLC**

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