# Test Criteria: 170.315.a.11 – Smoking Status

|  |  |
| --- | --- |
| **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)(11)-Smoking_Status)
* [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

|  |  |
| --- | --- |
| **Test Data Source:** | ONC-Supplied  DG-Supplied:  Developer-Supplied: |
| **Pre-Test Data Setup:**  Not applicable. | |
| **Test Data:**  Depending on smoking status implementation, DG-supplied test data may be used. | |
| **Test Tools:**  Not applicable. | |

# Demonstrate Standards Support

|  |  |
| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** Standard required for any health IT module certifying to a module that requires the exchange of the [Common Clinical Data Set](https://www.healthit.gov/sites/default/files/2015Ed_CCG_CCDS.pdf). For additional references, click [here](https://www.healthit.gov/policy-researchers-implementers/meaningful-use-stage-2-0/standards-hub) for the ONC Standards Hub. | |

|  |  |  |
| --- | --- | --- |
|  | **Standard** |  |
|  | §170.207(f)(h) | Smoking status must be coded in one of the following SNOMED CT® codes:   1. Current every day smoker 449868002 2. Current some day smoker 428041000124106 3. Former smoker 8517006 4. Never Smoker 266919005 5. Smoker, current status unknown 77176002 6. Unknown if ever smoked 266927001 7. Heavy tobacco smoker 428071000124103 8. Light tobacco smoker 428061000124105 |

# 170.315(a)(11)-Smoking Status

|  |  |
| --- | --- |
| **Test Result:** | PASS:  FAIL:  No Attempt: |
| **Instructions:** Use EHR functionality to record, change, and access a patient’s smoking status. | |
| **Expected Test Result:**  For a health IT module testing “Common Clinical Data Set”:   * Enable a user to record, change, and access smoking status using the (8) SNOMED CT smoking status codes. * SNOMED CT value is recorded correctly within the patient’s record either visible to the user, cross-referenced, or recorded within the implementation.   For a health IT module NOT testing “Common Clinical Data Set”:   * Enable a user to record, change, and access smoking status. * Smoking status type is recorded correctly. | |
| **Points to Remember:**   * SNOMED CT® is required for smoking status for the Common Clinical Data Set. Use “DG-Supplied” test data below. * No standard required if health IT module is not testing “Common Clinical Data Set”. Use “Health IT Developer-Supplied” test data below. * Criterion is limited to any form of tobacco that is smoked. A health IT system is not prohibited from capturing other forms of tobacco use that is not smoked, but this is out of scope for certification. | |

### Test Procedures

* 1. **DG-Supplied Test Data: Patient-1**

(Use if testing Common Clinical Data Set)

|  |  |
| --- | --- |
|  | User records smoking status: **Heavy Tobacco Smoker** **(428071000124103)** |
|  | User changes and saves each iteration of smoking status listed below:   * **Light Tobacco Smoker (428061000124105)** * **Current Every Day Smoker** **(449868002)** * **Current Some Day Smoker** **(428041000124106)** * **Former Smoker** **(8517006)** * **Never Smoker** **(266919005)** * **Smoker, Current Status Unknown** **(77176002)** * **Unknown if ever smoked** **(266927001)** |
|  | User accesses smoking status: **Unknown if ever smoked** **(266927001)** |

<INSERT SCREEN SHOTS>

**2.1 Health IT Developer-Supplied Test Data: Patient-1**

(Use if NOT testing Common Clinical Data Set)

|  |  |
| --- | --- |
|  | User records smoking status (no standard/vocabulary required) |
|  | User changes smoking status (no standard/vocabulary required) |
|  | User accesses smoking status (no standard/vocabulary required) |

<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

* No vocabulary standard required for recording smoking status for any health IT module that is NOT certifying to a module that requires the exchange of the “Common Clinical Data Set”.
* Any h*ealth* IT module certifying to a module that generates and tests the Common Clinical Data Set is required to record smoking status using the (8) SNOMED CT® codes.
* Syntax and wording can vary for smoking status (e.g. “never smoker” is the same as “never smoked”), but status must be clearly understood.
* Per ONC guidance, we understand that a “current every day smoker” or “current some day smoker” is an individual who has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes everyday or periodically, yet consistently; a “former smoker” would be an individual who has smoked at least 100 cigarettes during his/her lifetime but does not currently smoke; and a “never smoker” would be an individual who has not smoked 100 or more cigarettes during his/her lifetime. The other two statuses (smoker, current status unknown; and unknown if ever smoked) would be available if an individual’s smoking status is ambiguous. The status “smoker, current status unknown” would apply to individuals who were known to have smoked at least 100 cigarettes in the past, but their whether they currently still smoke is unknown. The last status of “unknown if ever smoked” is self-explanatory. Refer to the CDC guide for more details: <ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/datasets/DATA2010/Focusarea27/O2701a.pdf>.
* “’Light smoker’ is interpreted to mean less than 10 cigarettes per day, or an equivalent (but less concretely defined) quantity of cigar or pipe smoke. ‘Heavy smoker’ is interpreted to mean greater than 10 cigarettes per day or an equivalent (but less concretely defined) quantity of cigar or pipe smoke.”
* The test procedure is not prescriptive about the method used to change smoking status. For example, modifying a smoking status does not require modifying an existing instance of a smoking status. Modification may be accomplished through inactivating or deleting an existing smoking status in the patient’s EHR and entering a new instance of the smoking status.

# 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)(11) Smoking Status.**

Technology must enable a user to record, change, and access a patient’s smoking status.

**§170.207(h). Smoking Status. Standard.**

Smoking Status must be coded in one of the following SNOMED CT® codes for clinical data exchange:

(1) Current every day smoker. 449868002

(2) Current some day smoker. 428041000124106

(3) Former smoker. 8517006

(4) Never smoker. 266919005

(5) Smoker, current status unknown. 77176002

(6) Unknown if ever smoked. 266927001

(7) Heavy tobacco smoker. 428071000124103

(8) Light tobacco smoker. 428061000124105

# Change Log

|  |  |
| --- | --- |
| Revision | Change Description |
| 01-Mar-2016 | Initial Release |
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