Test Procedure for §170.314(a)(1) Computerized provider order entry


Questions or concerns regarding the ONC HIT Certification Program should be sent to:
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CERTIFICATION CRITERIA

This certification criterion is from the Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology, Final Rule issued by the Department of Health and Human Services (HHS) on September 4, 2012. This certification criterion is included in the definition of a Base EHR.

§170.314(a)(1) Computerized provider order entry. Enable a user to electronically record, change, and access the following order types, at a minimum:

(i) Medications;
(ii) Laboratory; and
(iii) Radiology/imaging. Diagnostic imaging

2014 EDITION RELEASE 2 PREAMBLE LANGUAGE

Per Section III.A.2 of the preamble of the 2014 Edition Release 2 Electronic Health Record (EHR) Certification Criteria and the ONC HIT Certification Program; Regulatory Flexibilities, Improvements, and Enhanced Health Information Exchange Final Rule (September 11, 2014), the “at a minimum” language in these certification criteria has not been included and the relevant regulation text of this certification criterion has been changed from “radiology and imaging orders” to “diagnostic imaging orders”.

2014 EDITION PREAMBLE LANGUAGE

Per Section III.A of the preamble of the Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology, Final Rule (September 4, 2012) where the computerized provider order entry certification criterion is discussed:
• “...we do clarify that the change in the CPOE denominator affects the “automated measure calculation” certification criterion (§ 170.314(g)(2)), which is a revised certification criterion for the 2014 Edition EHR certification criteria.”
• “This certification criterion focuses on enabling a user to electronically record, change, and access, at a minimum, medication, laboratory and radiology/imaging orders. It does not focus on transmission of those orders.”

2011 PREAMBLE LANGUAGE

Per Section III.D of the preamble of the Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, Final Rule (July 28, 2010) where the computerized provider order entry certification criterion is discussed:

• “We clarify that the adopted certification criteria related to CPOE pertain only to the ordering, and not to the delivery of results (reports or images).”

CHANGES FROM 2011 TO 2014 EDITION

Per Section III.A of the preamble of the Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology, Final Rule (September 4, 2014) where the computerized provider order entry certification criterion is discussed:

• “We proposed a CPOE certification criterion that merged the separate ambulatory and inpatient CPOE certification criteria in the 2011 Edition EHR certification criteria into one criterion because they those [sic] certification criteria are identical.”
• “We proposed to replace the terms “modify” and “retrieve” with “change” and “access,” respectively.”
• “We also proposed to remove the term “store” from the criterion because it is redundant with our interpretation of the term “record.””
• “…we proposed to move the phrase “at a minimum” in the certification criterion to eliminate any possible ambiguity as to what the phrase modifies. As proposed, the certification criterion made clear that the phrase modifies the order types and not the terms “record,” “change,” and “access.””

INFORMATIVE TEST DESCRIPTION

This section provides an informative description of how the test procedure is organized and conducted. It is not intended to provide normative statements of the certification requirements.

This test evaluates the capability for EHR technology to enable a user to electronically record, change, and access the following order types:

(i) Medications;
(ii) Laboratory; and
(iii) Diagnostic imaging.
The test procedure is not prescriptive about the method used to change an order. For example, changing an order does not require changing an existing instance of an order. Change may be accomplished through discontinuing/canceling an existing order and entering a new order.

ONC supplies part of the test data and the Vendor supplies part of the test data for this test procedure. This test procedure is organized into three sections:

- **Record** – evaluates the capability to electronically enter orders for medications, laboratory, and diagnostic imaging within the EHR system
  
  - The Tester enters the ONC-supplied test data orders for medications, laboratory, and diagnostic imaging
  
  - The Tester verifies that the orders are recorded in the EHR

- **Change** – evaluates the capability for a user to electronically change entered orders for medications, laboratory, and diagnostic imaging in the EHR
  
  - The Tester displays the entered orders for medications, laboratory, and diagnostic imaging
  
  - Tester changes the medications, laboratory, and diagnostic imaging orders
  
  - The Tester verifies that the changed orders are accurate and complete

- **Access** – evaluates the capability to access and display the orders that have been previously entered into the EHR
  
  - The Tester displays the orders for medications, laboratory, and diagnostic imaging entered during the test
  
  - The Tester verifies that the displayed order data are accurate and complete

For EHR technology **targeted to the ambulatory setting**, the following derived test requirements apply:

- DTR170.314(a)(1) – 1: Electronically Record Orders in an Ambulatory Setting
- DTR170.314(a)(1) – 2: Electronically Change Orders in an Ambulatory Setting
- DTR170.314(a)(1) – 3: Electronically Access Orders in an Ambulatory Setting

For EHR technology **targeted to the inpatient setting**, the following derived test requirements apply:

- DTR170.314(a)(1) – 4: Electronically Record Orders in an Inpatient Setting
- DTR170.314(a)(1) – 5: Electronically Change Orders in an Inpatient Setting
- DTR170.314(a)(1) – 6: Electronically Access Orders in an Inpatient Setting

**Referenced Standards**

None

**Normative Test Procedures – Ambulatory Setting**

**Derived Test Requirements**

- DTR170.314(a)(1) – 1: Electronically Record Orders in an Ambulatory Setting
- DTR170.314(a)(1) – 2: Electronically Change Orders in an Ambulatory Setting
- DTR170.314(a)(1) – 3: Electronically Access Orders in an Ambulatory Setting

DTR170.314(a)(1) – 1: Electronically Record Orders in an Ambulatory Setting

**Required Vendor Information**
VE170.314(a)(1) – 1.01: Vendor shall identify a patient with an existing record in the EHR to be used for this test

VE170.314(a)(1) – 1.02: Vendor shall identify the EHR function(s) that are available to: 1) select the patient, 2) enter orders for medications, laboratory, and diagnostic imaging, 3) change orders for medications, laboratory, and diagnostic imaging, and 4) access orders for medications, laboratory, and diagnostic imaging in an ambulatory setting

Required Test Procedure

TE170.314(a)(1) – 1.01: Tester shall select order test data from one ONC-supplied test data set in TD170.314(a)(1) – 1

TE170.314(a)(1) – 1.02: Using the EHR function(s) identified by the Vendor, the Tester shall select the patient’s existing record and enter orders from the selected test data set in TD170.314(a)(1) – 1 for

   • Medication
   • Laboratory
   • Diagnostic imaging

TE170.314(a)(1) – 1.03: Using the Inspection Test Guide (below), the Tester shall verify that the orders have been entered correctly and without omission

Inspection Test Guide

IN170.314(a)(1) – 1.01: Using the data in the selected ONC-supplied test data set in TD170.314(a)(1) – 1, Tester shall verify that the order test data are entered correctly and without omission

IN170.314(a)(1) – 1.02: Tester shall verify that the order data are recorded in the patient’s record for data elements listed in TE170.314(a)(1) – 1.02

DTR170.314(a)(1) – 2: Electronically Change Orders in an Ambulatory Setting

Required Vendor Information

   • As defined in DTR170.314(a)(1) – 1, no additional information is required

Required Test Procedure

TE170.314(a)(1) – 2.01: Tester shall select order test data from one ONC-supplied test data set in TD170.314(a)(1) – 2 that corresponds to the data set selected for DTR170.314(a)(1) – 1: Electronically Record Orders in an Ambulatory Setting

TE170.314(a)(1) – 2.02: Using the EHR function(s) identified by the Vendor, the Tester shall select the patient’s existing record, shall display the order data entered during the DTR170.314(a)(1) – 1: Electronically Record Orders in an Ambulatory Setting test, and shall change the previously entered orders for the data elements listed in TE170.314(a)(1) – 1.02

TE170.314(a)(1) – 2.03: Using the Inspection Test Guide (below), the Tester shall verify that the orders that were entered in TE170.314(a)(1) – 2.02 have been entered correctly and without omission

Inspection Test Guide

IN170.314(a)(1) – 2.01: Using the data in the selected ONC-supplied
test data set in TD170.314(a)(1) – 2, Tester shall verify that the medication, laboratory, and diagnostic imaging order data entered during the DTR170.314(a)(1) – 1: Electronically Record Orders in an Ambulatory Setting test are accessed and changed correctly and without omission

IN170.314(a)(1) – 2.02: Tester shall verify that the changed orders are recorded in the patient record correctly, including the data elements listed in TE170.314(a)(1) – 1.02

DTR170.314(a)(1) – 3: Electronically Access Orders in an Ambulatory Setting

Required Vendor Information

- As defined in DTR170.314(a)(1) – 1, no additional information is required

Required Test Procedure

TE170.314(a)(1) – 3.01: Using the EHR function(s) identified by the Vendor, the Tester shall select the patient’s existing record and display the orders the Tester entered during the DTR170.314(a)(1) – 1: Electronically Record Orders in an Ambulatory Setting test and changed during the DTR170.314(a)(1) – 2: Electronically Change Orders in an Ambulatory Setting test for the data elements listed in TE170.314(a)(1) – 1.02

TE170.314(a)(1) – 3.02: Using the Inspection Test Guide (below), the Tester shall verify that the order data display correctly and without omission

Inspection Test Guide

IN170.314(a)(1) – 3.01: Using the data in the ONC-supplied test data set in TD170.314(a)(1) – 3 that corresponds to the data set selected for DTR170.314(a)(1) – 1: Electronically Record Orders in an Ambulatory Setting, Tester shall verify that the order data entered during the DTR170.314(a)(1) – 1: Electronically Record Orders in an Ambulatory Setting test and changed during the DTR170.314(a)(1) – 2: Electronically Change Orders in an Ambulatory Setting test display correctly and without omission, including the data elements listed in TE170.314(a)(1) – 1.02

NORMATIVE TEST PROCEDURES –INPATIENT SETTING

Derived Test Requirements

DTR170.314(a)(1) – 4: Electronically Record Orders in an Inpatient Setting
DTR170.314(a)(1) – 5: Electronically Change Orders in an Inpatient Setting
DTR170.314(a)(1) – 6: Electronically Access Orders in an Inpatient Setting

DTR170.314(a)(1) – 4: Electronically Record Orders in an Inpatient Setting

Required Vendor Information

VE170.314(a)(1) – 4.01: Vendor shall identify a patient with an existing record in the EHR to be
used for this test

VE170.314(a)(1) – 4.02: Vendor shall identify the EHR function(s) that are available to: 1) select the patient, 2) enter orders for medications, laboratory, and diagnostic imaging, 3) change orders for medications, laboratory, and diagnostic imaging, and 4) access orders for medications, laboratory, and diagnostic imaging in an inpatient setting

Required Test Procedure

TE170.314(a)(1) – 4.01: Tester shall select order test data from one ONC-supplied test data set in TD170.314(a)(1) – 4

TE170.314(a)(1) – 4.02: Using the EHR function(s) identified by the Vendor, the Tester shall select the patient’s existing record and enter orders from the selected test data set in TD170.314(a)(1) – 4 for:
- Medications
- Laboratory
- Diagnostic imaging

TE170.314(a)(1) – 4.03: Using the Inspection Test Guide (below), the Tester shall verify that the orders have been entered correctly and without omission

Inspection Test Guide

IN170.314(a)(1) – 4.01: Using the data in the selected ONC-supplied test data set in TD170.314(a)(1) – 4, Tester shall verify that the order test data are entered correctly and without omission

IN170.314(a)(1) – 4.02: Tester shall verify that the order data are recorded in the patient’s record for the data elements listed in TE170.314(a)(1) – 4.02

DTR170.314(a)(1) – 5: Electronically Change Orders in an Inpatient Setting

Required Vendor Information
- As defined in DTR170.314(a)(1) – 4, no additional information is required

Required Test Procedure

TE170.314(a)(1) – 5.01: Tester shall select order test data from one ONC-supplied test data set in TD170.314(a)(1) – 5 that corresponds to the data set selected for DTR170.314(a)(1) – 4: Electronically Record Orders in an Inpatient Setting

TE170.314(a)(1) – 5.02: Using the EHR function(s) identified by the Vendor, the Tester shall select the patient’s existing record, shall display the order data entered during the DTR170.314(a)(1) – 4: Electronically Record Orders in an Inpatient Setting test, and shall change the previously entered orders for the data elements listed in TE170.314(a)(1) – 4.02

TE170.314(a)(1) – 5.03: Using the Inspection Test Guide (below), the Tester shall verify that the orders that were entered in TE170.314(a)(1) – 5.02 have been entered correctly and without omission

Inspection Test Guide

IN170.314(a)(1) – 5.01: Using the data in the selected ONC-supplied test data set in TD170.314(a)(1) – 5, Tester shall verify that the medication, laboratory,
and diagnostic imaging order data entered during the DTR170.314(a)(1) – 4: Electronically Record Orders in an Inpatient Setting test are accessed and changed correctly and without omission.

IN170.314(a)(1) – 5.02: Tester shall verify that the changed orders are recorded in the patient record correctly, including the data elements listed in TE170.314(a)(1) – 4.02.

DTR170.314(a)(1) – 6: Electronically Access Orders in an Inpatient Setting

Required Vendor Information
- As defined in DTR170.314(a)(1) – 4, no additional information is required.

Required Test Procedure

TE170.314(a)(1) – 6.01: Using the EHR function(s) identified by the Vendor, the Tester shall select the patient’s existing record and display the orders the Tester entered during the DTR170.314(a)(1) – 4: Electronically Record Orders in an Inpatient Setting test and changed during the DTR170.314(a)(1) – 5: Electronically Change Orders in an Inpatient Setting test for the data elements listed in TE170.314(a)(1) – 4.02.

TE170.314(a)(1) – 6.02: Using the Inspection Test Guide (below), the Tester shall verify that the order data display correctly and without omission.

Inspection Test Guide

IN170.314(a)(1) – 6.01: Using the data in the ONC-supplied test data set in TD170.314(a)(1) – 6 that corresponds to the data set selected for DTR170.314(a)(1) – 4: Electronically Record Orders in an Inpatient Setting, Tester shall verify that the order data entered during the DTR170.314(a)(1) – 4: Electronically Record Orders in an Inpatient Setting test and changed during the DTR170.314(a)(1) – 5: Electronically Change Orders in an Inpatient Setting test display correctly and without omission, including the data elements listed in TE170.314(a)(1) – 4.02.

Test Data

ONC- and Vendor-supplied test data are provided with the test procedure to ensure that the applicable requirements identified in the criteria can be adequately evaluated for conformance, as well as to provide consistency in the testing process across multiple National Voluntary Laboratory Accreditation Program (NVLAP)-Accredited Testing Labs (ATLs). The provided test data focus on evaluating the basic capabilities of required EHR technology, rather than exercising the full breadth/depth of capability that installed EHR technology might be expected to support. The test data are formatted for readability of use within the testing process. The format is not prescribing a particular end-user view or rendering. No additional requirements should be drawn from the format.

The Tester shall use and apply the provided test data during the test, without exception, unless one of the following conditions exists:

- The test procedure requires or permits the use of vendor-supplied test data.
The Tester determines that the Vendor product is sufficiently specialized that the provided test data needs to be modified in order to conduct an adequate test. Having made the determination that some modification to the provided test data is necessary, the Tester shall record the modifications made as part of the test documentation.

The Tester determines that changes to the test data will improve the efficiency of the testing process; primarily through using consistent demographic data throughout the testing workflow. The Tester shall ensure that the applicable requirements identified in the criterion can be adequately evaluated for conformance and that the test data provides a comparable level of robustness. Having made the determination that some modification to the provided test data is necessary, the Tester shall record the modifications made as part of the test documentation.

Any departure from the provided test data shall strictly focus on meeting the basic capabilities required of EHR technology relative to the certification criterion rather than exercising the full breadth/depth of capability that installed EHR technology might be expected to support.

The test procedures require that the Tester enter the applicable test data into the EHR technology being evaluated for conformance. The intent is that the Tester fully controls the process of entering the test data in order to ensure that the data are correctly entered as specified in the test procedure. If a situation arises where it is impractical for a Tester to directly enter the test data, the Tester, at the Tester’s discretion, may instruct the Vendor to enter the test data, so long as the Tester remains in full control of the testing process, directly observes the test data being entered by the Vendor, and validates that the test data are entered correctly as specified in the test procedure.

For Vendor-supplied test data, the Tester shall address the following:

- Vendor-supplied test data shall ensure that the requirements identified in the criterion can be adequately evaluated for conformance.
- Vendor-supplied test data shall strictly focus on meeting the basic capabilities required of an EHR relative to the certification criterion rather than exercising the full breadth/depth of capability that an installed EHR might be expected to support.
- Tester shall record as part of the test documentation the specific Vendor-supplied test data that was utilized for testing.

For additional information regarding the provided test data for use in this test procedure:


**Conformance Test Tools**

None
## Document History

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<tr>
<th>Version Number</th>
<th>Description of Change</th>
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<tbody>
<tr>
<td>1.0</td>
<td>Released for public comment</td>
<td>September 7, 2012</td>
</tr>
<tr>
<td>1.1</td>
<td>Delivered for National Coordinator Approval</td>
<td>December 4, 2012</td>
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<tr>
<td>1.2</td>
<td>Posted Approved Test Procedure</td>
<td>December 14, 2012</td>
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<tr>
<td>1.3</td>
<td>Removal of following sections: “For EHR technology targeted to both settings, the following derived test requirements”&lt;br&gt;Addition of the following section: 2014 Edition Release 2 Preamble Language&lt;br&gt;The Test Procedure has been update to reflect the 2014 Edition Release 2 rule and removes the “at a minimum” language. The text of this certification criterion has been changed from “radiology and imaging orders” to “diagnostic imaging orders”.&lt;br&gt;The test steps have been changed to reflect “diagnostic imaging” instead of “radiology/imaging”</td>
<td>December 19, 2014</td>
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