

## Test Procedure for §170.314(a)(17) Advance directives – inpatient setting only

This document describes the test procedure for evaluating conformance of electronic health record (EHR) technology to the certification criteria defined in 45 CFR Part 170 Subpart C 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. The document<sup>1</sup> is organized by test procedure and derived test requirements with traceability to the normative certification criteria as described in the Overview document located at <http://www.healthit.gov/certification> (navigation: 2014 Edition Test Method). The test procedures may be updated to reflect on-going feedback received during the certification activities.

The Department of Health and Human Services (HHS)/Office of the National Coordinator for Health Information Technology (ONC) has defined the standards, implementation guides and certification criteria used in this test procedure. Applicability and interpretation of the standards, implementation guides and certification criteria to EHR technology is determined by ONC. Testing of EHR technology in the Permanent Certification Program, henceforth referred to as the ONC Health Information Technology (HIT) Certification Program<sup>2</sup>, is carried out by National Voluntary Laboratory Accreditation Program (NVLAP)-Accredited Testing Laboratories (ATLs) as set forth in the final rule establishing the Permanent Certification Program (*Establishment of the Permanent Certification Program for Health Information Technology, 45 CFR Part 170; February 7, 2011*).

Questions or concerns regarding the ONC HIT Certification Program should be directed to ONC at [ONC.Certification@hhs.gov](mailto:ONC.Certification@hhs.gov).

### CERTIFICATION CRITERION

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.

§170.314(a)(17) Inpatient setting only – Advance directives. Enable a user to electronically record whether a patient has an advance directive.

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

---

<sup>1</sup> Disclaimer: Certain commercial products may be identified in this document. Such identification does not imply recommendation or endorsement by ONC.

<sup>2</sup> 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.

to the Permanent Certification Program for Health Information Technology, Final Rule, the 2014 Edition of this certification criterion is classified as unchanged without refinements from the 2011 Edition. This certification criterion meets the three factors of unchanged certification criteria: (1) the certification criterion includes only the same capabilities that were specified in previously adopted certification criteria, (2) the certification criterion's capabilities apply to the same setting as they did in previously adopted certification criteria, and (3) the certification criterion remains designated as "mandatory," or it is re-designated as "optional," for the same setting for which it was previously adopted certification criterion.

## 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 advance directives certification criterion is discussed:

- "This certification criterion's scope focuses on the capabilities necessary to support MU, which requires the recording of whether a patient 65 years old or older has an advance directive. A patient's advance directive is not required to be available or accessible with EHR technology. Under MU, advance directive information is also not included in the summary care record, required to be provided after a patient's office visit, or required to be available for online viewing or downloading by a patient."
- "We clarify that EHR technology would only need to demonstrate that it can include an advance directive indicator and that the indicator is stored in the patient's record. The use of "yes" and "no" data fields may be one method for EHR technology to meet this certification criterion."
- "A Boolean search capability based on patients with advance directives is not a requirement to meet this certification criterion."

## 2011 EDITION PREAMBLE LANGUAGE

None referenced

## 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, 2012) where the advance directives certification criterion is discussed:

- "We proposed to include the following unchanged certification criteria in the 2014 Edition EHR certification criteria without any substantial refinements, except, where appropriate, replacing the terms "generate," "modify," and "retrieve" with "create," "change," and "access," respectively."

## 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 whether a patient has an advance directive.

The Vendor supplies the test data for this test procedure.

This test procedure consists of one section:

- Record – evaluates the capability to enter into the EHR whether a patient has an advance directive
  - The Tester enters an advance directive indicator or advance directive content into the EHR

## REFERENCED STANDARDS

None

## NORMATIVE TEST PROCEDURES

### Derived Test Requirements

DTR170.314(a)(17) – 1: Electronically Record Patient Advance Directive

### **DTR170.314(a)(17) – 1: Electronically Record Patient Advance Directive**

#### Required Vendor Information

VE170.314(a)(17) – 1.01: Vendor shall identify a patient with an existing record in the EHR

VE170.314(a)(17) – 1.02: Vendor shall provide the advance directive indicator/content for this test

VE170.314(a)(17) – 1.03: Vendor shall identify the EHR function(s) that are available to: 1) select the patient, 2) enter patient advance directive indicator/content

#### Required Test Procedure

TE170.314(a)(17) – 1.01: Tester shall select patient advance directive indicator/content from the Vendor-supplied data

TE170.314(a)(17) – 1.02: Using the EHR function(s) identified by the Vendor, the Tester shall select the patient's existing record and enter patient advance directive indicator/content from the Vendor-supplied data

TE170.314(a)(17) – 1.03: Using the Inspection Test Guide (below), the Tester shall verify that the patient advance directive indicator/content has been entered correctly and without omission

### Inspection Test Guide

IN170.314(a)(17) – 1.01: Using the Vendor-supplied advance directive indicator/content, Tester shall verify that the patient advance directive information is entered correctly and without omission

IN170.314(a)(17) – 1.02: Tester shall verify that the patient advance directive indicator/content is stored in the patient's record

## TEST DATA

The Vendor shall supply the test data for this test procedure.

Vendor-supplied test data shall 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.

## CONFORMANCE TEST TOOLS

None

## Document History

Version Number	Description of Change	Date
1.0	Released for public comment	September 7, 2012
1.1	Delivered for National Coordinator Approval	December 4, 2012
1.2	Posted Approved Test Procedure	December 14, 2012