

2015 Edition §170.315(a)(12) Family Health History				
Testing Components:				
Test Procedure Version 1.0 – Last Updated 1/08/16				

Please consult the Final Rule entitled: *2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications* for a detailed description of the certification criterion with which these testing steps are associated. We also encourage developers to consult the Certification Companion Guide in tandem with the test procedure as they provide clarifications that may be useful for product development and testing.

*Note: The order in which the test steps are listed reflects the sequence of the certification criterion and does not necessarily prescribe the order in which the test should take place.*

### Required Tests

**(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).

**Standard(s):** § 170.207(a)(4) -International Health Terminology Standards Development Organization (IHTSDO) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, September 2015 Release; available at:

[http://www.nlm.nih.gov/research/umls/Snomed/us\\_edition.html](http://www.nlm.nih.gov/research/umls/Snomed/us_edition.html)

Criteria ¶	System Under Test	Test Lab Verification
(12)	<ol style="list-style-type: none"> <li>The user selects a patient’s record and records the patient’s family health history in accordance with the familial concepts or expressions included in the standard specified in § 170.207(a)(4).</li> <li>The user accesses the patient’s family health history and changes the family health history in accordance with the familial concepts or expressions included in the standard specified in § 170.207(a)(4).</li> </ol>	<ol style="list-style-type: none"> <li>The tester verifies the user can record the patient’s family health history in accordance with the familial concepts or expressions included in the standard specified in §170.207(a)(4).</li> <li>The tester verifies the user can access and change the patient’s family health history in accordance with the familial concepts or expressions included in the standard specified in § 170.207(a)(4).</li> </ol>

### Document History

Version Number	Description of Change	Date
1.0	Final Test Procedure	January 08, 2016

**Dependencies:** For all related and required criteria, please refer to the [Master Table of Related and Required Criteria](#).