

| 2015 Edition §170.315(b)(9)<br>Care Plan  |   |   |   |      |   |
|---|---|---|---|------|---|
| Testing Components:   |   |   |   |      |   |
|  |  |  |  | Data |  |
| Test Procedure Version 1.1 – Last Updated 10/29/15                                |   |   |   |      |   |

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

#### (b)(9) Enable a User to Record, Change, Access, Create, and Receive Care Plan

Enable a user to record, change, access, create, and receive care plan information in accordance with the Care Plan document template, including the Health Status Evaluations and Outcomes Section and Interventions Section (V2), in the standard specified at §170.205(a)(4).

**Standards:** §170.205(a)(4) [HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes, Draft Standard for Trial Use, Release 2.1](#)

**Test Data:** [C-CDA Validator within the Edge Testing Tool](#)

Inpatient setting: - 170.315\_b9\_cp\_inp\_sample\*.docx (All Samples)

Ambulatory setting - 170.315\_b9\_cp\_amb\_sample\*.docx (All Samples)

All settings: 170.315\_b9\_cp\_sample\*.xml (All Samples)

Negative testing: 170.315\_b9\_cp\_sample\*.xml (All Samples)

**Test Tool:** [C-CDA Validator within the Edge Testing Tool](#)

| Criteria ¶ | System Under Test  | Test Lab Verification   |
|------------|--|---|
| (b)(9)     | <ol style="list-style-type: none"> <li>1. Based upon the health IT setting(s) ambulatory and/or inpatient, a user enters the care plan information for each of the ambulatory and/or inpatient test cases referenced from the care plan sample documents into the Health IT Module. All test cases for a given health IT setting are required. The user retrieves the required Care Plan instructions for entering data into the Health IT Module from the top-level C-CDA Validator, one of the tool selections within the Edge Testing Tool.</li> <li>2. Using the C-CDA Validator, the user selects the ambulatory and/or inpatient Care Plan documents (pdf) and select download to download the required care plan information documents.</li> <li>3. The user records care plan information that includes the following: <ul style="list-style-type: none"> <li>• Patient Name</li> <li>• Goals</li> <li>• Health Concerns</li> <li>• Health Status Evaluations and Outcomes</li> <li>• Interventions</li> </ul> </li> </ol> | <p>The tester verifies that that the outlined care plan information has been recorded correctly and without omission through Visual Inspection of the system under test using the Test data associated with the selected test case.</p> |
| (b)(9)     | <p>Using the Health IT Module, the user access the recorded care plan information for the specific patient.</p>  | <p>The tester verifies that care plan information can be accessed, is complete and accurate.</p>  |

| Criteria ¶ | System Under Test  | Test Lab Verification  |
|------------|--|--|
| (b)(9)     | <p>Using the Health IT Module, the user changes the care plan information for the specific patient that includes the following:</p> <ul style="list-style-type: none"> <li>• Patient Name</li> <li>• Goals</li> <li>• Health Concerns</li> <li>• Health Status Evaluations and Outcomes</li> <li>• Interventions.</li> </ul>   | <p>The tester verifies that care plan information can be changed is complete and accurate.</p>   |
| (b)(9)     | <p>1. For each test case, the Health IT Module, the user creates a care plan document formatted in accordance with the Care Plan document template in the standard adopted at §170.205(a)(4), HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes, Draft Standard for Trial Use, Release 2.1, and includes the Health Status Evaluations and Outcomes Section and Interventions Section (V2) which at a minimum includes the</p> <ul style="list-style-type: none"> <li>• Patient Name</li> <li>• Goals</li> <li>• Health Concerns</li> <li>• Health Status Evaluations and Outcomes</li> <li>• Interventions.</li> </ul> | <p>1. Validation of a Care Plan document is done using the C-CDA Validator, one of the tool selections within the Edge Testing Tool. To validate the Care Plan (xml file) created by the Health IT Module, the tester uses the C-CDA Validator Tool within the Edge Testing Tool to select the criteria to be verified based upon the originally downloaded test case document and upload the Care Plan created by the Health IT Module.</p> <p>2. For each test case, the tester uploads the care plan xml file created by the Health IT Module into the C-C-CDA Validator for validation based on each test case listed, and uses the Validation Report produced by the test tool to verify the validation report indicates passing without error to confirm that the care plan is conformant to the standard specified at §170.205(a)(4) and includes the Health Status Evaluations and Outcomes Section and Interventions Section (V2).</p> <p>3. As required by the test case, the tester uses the ONC-supplied supplied Care Plan document and the Care Plan xml file the in step 2 to verify through Visual Inspection, the additional checks for equivalent text for content for all section level narrative text.</p> |

| Criteria ¶ | System Under Test  | Test Lab Verification   |
|------------|--|---|
| (b)(9)     | <ol style="list-style-type: none"> <li>1. Using the top-level C-CDA Validator, one of the tool selections within the Edge Testing Tool, the user selects the Care Plan documents (xml) and selects download to download the required care plan xml files.</li> <li>2. Using the Health IT Module, a user receives the care plan (xml files) for each of the test cases retrieved from the C-CDA Validator. All test cases are required.</li> <li>3. For each of the test cases, the user receives care plan information from a third party that is formatted in accordance with the Care Plan document template in the standard adopted at §170.205(a)(4), HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes, Draft Standard for Trial Use, Release 2.1, and includes the Health Status Evaluations and Outcomes Section and Interventions Section (V2) which at a minimum includes the <ul style="list-style-type: none"> <li>• Patient Name</li> <li>• Goals</li> <li>• Health Concerns</li> <li>• Health Status Evaluations and Outcomes</li> <li>• Interventions.</li> </ul> </li> <li>4. Negative Testing: A user receives a series of invalid C-CDA document types referenced from the Negative sample documents into the Health IT Module. All test cases for a given health IT setting are required.</li> <li>5. Using the top-level C-CDA Validator, one of the tool selections within the Edge Testing Tool, the user selects the Negative Test documents (xml) and selects download to download the required care plan xml files.</li> </ol> | <ol style="list-style-type: none"> <li>1. For each test case, the tester verifies that the Health IT Module can receive a Care Plan document formatted in accordance with the HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes, Draft Standard for Trial Use, Release 2.1 and includes the Health Status Evaluations and Outcomes Section and Interventions Section (V2) using Visual Inspection .</li> <li>2. Using the Health IT Module, the tester verifies that the Care Plan document received in step 1 is accurate and without omission through the Visual Inspection.</li> <li>3. Negative Test: For each of test case, the tester uses Visual Inspection to verify that the Health IT Module can successfully identify errors in the C-CDA documents not specified in accordance with the standards adopted in § 170.205(a)(4) including: <ul style="list-style-type: none"> <li>• “document-templates”</li> <li>• “section-templates”</li> <li>• “entry-templates”</li> <li>• Invalid vocabulary standards</li> <li>• Invalid codes.</li> </ul> </li> </ol> |

| Criteria ¶ | System Under Test  | Test Lab Verification |
|------------|--|-----------------------|
|            | <p>6. Using the Health IT Module, a user receives the Negative Test (xml files) for each of the test cases retrieved from the C-CDA Validator. All test cases are required.</p> <p>7. The user receives the applicable C-CDA document types containing errors in the corresponding “document-templates”, “section-templates”, and “entry-templates” including invalid vocabulary standards and codes not specified in the standards adopted in at §170.205(a)(4), HL7 Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes, Draft Standard for Trial Use, Release 2.1, and reports the errors.</p> |                       |

#### Document History

| Version Number | Description of Change       | Date             |
|----------------|-----------------------------|------------------|
| 1.0            | Released for Comment - NPRM | March 31, 2015   |
| 1.1            | Released for Comment - FR   | October 29, 2015 |

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