Test Scripts
For Preliminary ARRA IFR Stage 1 Certification
EHR Technology for Eligible Providers

April 7th, 2010

Product (NUMBER CODE ONLY):_____

Date: _____

Evaluator: _____

Signature: _____

COMPONENT A: Computer Physician Order Entry

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
A.01	Place an order for each of the following order types: • Medications; • Laboratory; • Radiology/Imaging; and • Provider Referrals Retrieve the order for Imaging and modify it in some way. Display the updated order.	Ability to electronically record, store, retrieve and manage the following order types: • Medications; • Laboratory; • Radiology/Imaging; and • Provider Referrals is demonstrated.		❑ Pass	❑ Fail	IFR.EP.A.1	Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types: 1. Medications; 2. Laboratory; 3. Radiology/imaging; and 4. Provider referrals.	If applying for quality measure reporting, ensure that the provider who entered the order is stored.

COMPONENT B: Drug Decision Support

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
B.01	Automatically and electronically generate and indicate in real-time alerts at the point of care for drug-drug and drug-allergy contraindications based on: • Medication list; • Medication allergy list; and • Age	Ability to automatically and electronically generate drug-drug and drug-allergy contraindication alerts based on: • Medication list; • Medication allergy list; and • Age is demonstrated.		❑ Pass	❑ Fail	IFR.EP.B.1	Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, age, and CPOE.	

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
B.02	Applicant will provide copy of a pre-approved ePrescribing network certificate that covers Formulary Checking.	Ability to check formulary is demonstrated by providing a copy of the pre-approved ePrescribing network certificate that covers Formulary Checking.		❑ Pass	❑ Fail	IFR.EP.B.2	Enable a user to electronically check if drugs are in a formulary or preferred drug list in accordance with the standard specified in Table 2A row 2 (i.e. NCPDP Formulary & Benefits Standard 1.0).	
B.03	Show how the severity level at which drug interaction warnings appear to providers can be set/changed.	Ability to deactivate, modify, and add rules for drug-drug and drug-allergy checking is demonstrated.		❑ Pass	❑ Fail	IFR.EP.B.3	Provide certain users with administrator rights to deactivate, modify, and add rules for drug-drug and drug-allergy checking.	The scenario described in the Procedure is only an example; Applicants may use a different scenario to demonstrate this step.
B.04	Generate a report of all alerts which have been presented to providers over a set timeframe including the provider response to those alerts and notifications.	Report is generated, and includes all alerts, provider name and provider response. At a minimum, the alerts from Step B.01 should be present in the report.		❑ Pass	❑ Fail	IFR.EP.B.4	Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.	

COMPONENT C: PROBLEM LIST

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
C.01	Display the patient's current problem list and add a new problem. Modify the problem just added and display the updated problem list. All problems must be based on ICD-9-CM or SNOMED CT.	Ability to electronically record, modify, and retrieve a patient's problem list based on ICD-9-CM or SNOMED CT is demonstrated.		❑ Pass	❑ Fail	IFR.EP.C.1	Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care (i.e., over multiple office visits) in accordance with the applicable standards specified in Table 2A row 1 (ICD-9-CM or SNOMED CT).	

COMPONENT D: ELECTRONIC PRESCRIBING

Setup Information for Electronic Prescribing:

- Pharmacy Name: CCHIT Test Pharmacy Two
- NCPDP ID: 9123453
- Pharmacy Address: 200 S Wacker Drive, Suite 3100, Chicago, IL, 60606
- Prescriber Registered with CCHIT Pre-Approved ePrescribing Network: Dr. Internist E. Butler MD

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference	Comments
D.01	Demonstrate the ability of the technology to generate a prescription and transmit it electronically to the CCHIT Test Pharmacy Two.	Prescription is generated and transmitted to the CCHIT Test Pharmacy Two electronically.		❑ Pass	❑ Fail	IFR.EP.D.1 Enable a user to electronically transmit medication orders (prescriptions) for patients in accordance with the standards specified in Table 2A row 3. NCPDP SCRIPT 8.1 or NCPDP SCRIPT 8.1 and NCPDP SCRIPT 10.6. Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm+.	

COMPONENT E: MEDICATION LIST

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
E.01	Display a patient's active medication list and discontinue a medication. Record a new medication for the patient. Display the patient's medication history. Applicable standards as defined in the criterion must be used.	Ability to electronically record, modify, and retrieve a patient's active medication list and their medication history using the applicable standard is demonstrated.		❑ Pass	❑ Fail	IFR.EP.E.1	Enable a user to electronically record, modify, and retrieve a patient's active medication list as well as medication history for longitudinal care (i.e., over multiple office visits) in accordance with the applicable standard specified in Table 2A row 1. Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm+.	

COMPONENT F: MEDICATION ALLERGY LIST

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
F.01	Display a patient's active medication allergy list and remove an allergy. Record a new allergy for the patient. Display the patient's medication allergy history.	Ability to electronically record, modify, and retrieve a patient's active medication allergy list and medication allergy history is demonstrated.		❑ Pass	❑ Fail	IFR.EP.F.1	Enable a user to electronically record, modify, and retrieve a patient's active medication allergy list as well as medication allergy history for longitudinal care (i.e., over multiple office visits).	

COMPONENT G: DEMOGRAPHICS

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
G.01	Select a patient record, and add the following patient demographics: • Preferred language; • Insurance type; • Gender; • Race; • Ethnicity; and • Date of birth After saving the above information and exiting the demographics area, you realize the ethnicity entered was incorrect. Retrieve the demographics data and modify the ethnicity.	Ability to electronically record, modify, and retrieve patient demographics including: • Preferred language; • Insurance type; • Gender; • Race; • Ethnicity; and • Date of birth is demonstrated.		❑ Pass	❑ Fail	IFR.EP.G.1	Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, insurance type, gender, race, ethnicity, and date of birth.	Applicants may register a new patient for this step if necessary.

COMPONENT I: VITAL SIGNS

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
I.01	Demonstrate the ability to electronically record, modify, and retrieve vital signs: • Height; • Weight; • Blood pressure; • Temperature; and • Pulse After saving the above information and exiting the vital signs area, you realize the pulse was entered incorrectly. Retrieve the vital signs and modify the pulse.	Ability to electronically record, modify, and retrieve vital signs: • Height; • Weight; • Blood pressure; • Temperature; and • Pulse is demonstrated.		❑ Pass	❑ Fail	IFR.EP.I.1	Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, the height, weight, blood pressure, temperature, and pulse.	
I.02	System automatically calculates and displays BMI based on patient's height and weight.	Ability to automatically calculate and display BMI based on patient's height and weight is demonstrated.		❑ Pass	❑ Fail	IFR.EP.I.2	Automatically calculate and display body mass index (BMI) based on a patient's height and weight.	
I.03	For a 20 year old patient, demonstrate how the system plots height, weight and BMI over time and electronically display growth charts showing height, weight, and BMI compared to statistical norms for the age range of 2-20 years old.	Growth charts are displayed for height, weight and BMI showing actual values entered between 2-20 years for the selected patient and compared to statistical norms over time.		❑ Pass	❑ Fail	IFR.EP.I.3	Plot and electronically display, upon request, growth charts (height, weight, and BMI) for patients 2-20 years old.	Growth charts show actual data compared To statistical norms for gender and age.

COMPONENT J: SMOKING STATUS

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
J.01	Electronically record a smoking status of: Current Smoker and save this status to a patient record. Patient now states they do not smoke. Modify the smoking status of the patient. Other available choices for selection include: Former Smoker or Never Smoked. Select Former Smoker and save the updated status to the patient record.	Status of "Current Smoker" is recorded. Status is then updated to "Former Smoker". Available choices for selection of smoking status must include: • Current Smoker • Former Smoker • Never Smoked		❑ Pass	❑ Fail	IFR.EP.J.1	Enable a user to electronically record, modify, and retrieve the smoking status of a patient to: current smoker, former smoker, or never smoked.	

COMPONENT K: LAB TEST RESULTS

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
K.01	Demonstrate receipt of electronic lab results for a test patient.	Lab results are received into the EHR and include the following: • Name and address of the lab that processed the specimen, • the name and/or ID number of the patient, • the date the test was performed, • specimen source when appropriate, • the test name, result (value), and unit are correctly displayed as discrete data (vs. report format), • test report must indicate information regarding the condition and disposition of any specimens that do not meet the laboratory's criteria for acceptability.		❑ Pass	❑ Fail	IFR.EP.K.1 Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. IFR.EP.K.2 Electronically display in human readable format any clinical laboratory tests that have been received with LOINC® codes. IFR.EP.K.3 Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7).6 (1) For positive patient identification, either the patient's name or identification number, or a unique patient identifier and identification number. (2) The name and address of the laboratory location where the test was performed. (3) The test report date. (4) The test performed. (5) Specimen source, when appropriate. (6) The test result and, if applicable, the units of measurement or interpretation, or both. (7) Any information regarding the condition and disposition of specimens that do not meet the laboratory's criteria for acceptability. IFR.EP.K.4. Enable a user to electronically update a patient's record based upon received laboratory test results.	Applicants must refer to the document ***Preliminary ARRA IFR Stage 1 Interoperability Test Guide and Applicant Form*** for detailed information on the execution of this step. CCHIT will not provide the lab file used for this step. The Applicant should prepare a file for the patient of their choice, with lab results of their choice, using the required HL7 format, and be prepared to demonstrate the receipt of the file, incorporation of results into the patient record, and display of all required elements listed in the Expected Results. Results are required to be in discrete data fields to allow their use in quality measure reporting.

COMPONENT L: PATIENT LISTS

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
L.01	Create a report of all patients over the age of 50 with Diabetes who have been prescribed insulin. Demonstrate the ability to sort the list by different parameters such as age, provider name or visit date for example. Report is able to be saved as an electronic document.	Ability to electronically select, sort, retrieve, and output a list of patients and patient's clinical information, based on user-defined: • Demographic data • Medication list • Specific conditions is demonstrated.		❑ Pass	❑ Fail	IFR.EP.L.1	Enable a user to electronically select, sort, retrieve, and output a list of patients and patients' clinical information, based on user-defined demographic data, medication list, and specific conditions.	The scenario described in the Procedure is only an example; Applicants may use a different scenario to demonstrate this step.

COMPONENT M: CMS QUALITY REPORTING

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
M.01	Create the following reports supporting core quality measure reporting to CMS including: • A statistical report based on BP measurements limited to patients over 18 with a diagnosis of hypertension • % of patients who were queried about smoking status • Report that includes patients over 65 who have received one or more drugs on a specific list (e.g. Beers list)	The system has the ability to generate quality measure results including performing calculations and electronically displaying the information.		❑ Pass	❑ Fail	IFR.EP.M.1	Calculate and electronically display quality measure results as specified by CMS or states.	If the EHR technology does not support the clinical component required in a report (e.g. recording vital signs), it is exempt from generating that report. "Specific list" referred to in 3rd bullet can be Beers list or another list of the applicants choosing. Applicants must show the list that was used to the inspector.

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
M.02	Demonstrate the ability to electronically submit quality measures in accordance with the specified standard of PQRI 2008 XML. Using the results of one of the reports created in Step M.01 create a file using the specified standard and submit the file to the CCHIT Proctor for validation.	The quality measure file is validated by CCHIT as properly formatted and structured using the PQRI 2008 XML standard.		❑ Pass	❑ Fail	IFR.EP.M.2	The system shall provide the ability for a user to electronically submit calculated quality measures in accordance with the specified standard of PQRI 2008 XML.	The published IFR indicates that other standards may be used to submit quality measures; therefore, this step is optional at this time.

COMPONENT N: PATIENT REMINDERS

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
N.01	Generate a report that shows patients due for a specific preventive or follow-up care service based on demographic data, specific conditions, and/or medications. The report should show each patient's preference for receiving these reminders. Conversely, the report itself could use patient preference as a criterion for generating the report (e.g. include patients who prefer to receive reminders via mail).	Ability to electronically generate a patient reminder list for preventive or follow-up care according to patient preferences based on demographic data, specific conditions, and/or medication list is demonstrated.		❑ Pass	❑ Fail	IFR.EP.N.1	Electronically generate, upon request, a patient reminder list for preventive or follow-up care according to patient preferences based on demographic data, specific conditions, and/or medication list.	The scenario described in the Procedure is only an example; Applicants may use a different scenario to demonstrate this step.

COMPONENT O: CLINICAL DECISION RULE

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
O.01	Demonstrate the ability to set up a Decision Support Rule to alert the user to "call physician" if the blood glucose test result is less than 70 for any patient over the age of 60 years with Diabetes. Select a patient who is over 60 with Diabetes and add a blood glucose test result of 68.	Ability to implement an automated, electronic clinical decision support rule(s) that uses demographic data, specific diagnoses, conditions, diagnostic test results and/or medications to trigger an alert is demonstrated. Alerts are triggered appropriately when data that meets the requirements is entered.		❑ Pass	❑ Fail	IFR.EP.O.1 IFR.EP.O.2	Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) according to specialty or clinical priorities that use demographic data, specific patient diagnoses, conditions, diagnostic test results and/or patient medication list. Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts and care suggestions based upon clinical decision support rules and evidence grade.	Applicants may create more than one rule to demonstrate all the required elements in the criteria. The scenario described in the Procedure is only an example; Applicants may use a different scenario to demonstrate this step.
O.02	Generate a report of all alerts which occurred during the previous test steps including the provider's response to those alerts.	Ability to generate a report of all alerts which occurred during the previous test steps including the provider's response to those alerts is demonstrated.		❑ Pass	❑ Fail	IFR.EP.O.3	Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.	

COMPONENT Q: INSURANCE ELIGIBILITY

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
Q.01	Check a patient's insurance eligibility by submitting an electronic insurance eligibility query to a public and a private payer and receive and display the returned eligibility responses, record them in the patient record.	Ability to query for patient insurance eligibility and display the medical eligibility response obtained from patient's insurance carrier is demonstrated. The response is recorded in the patient record.		❑ Pass	❑ Fail	IFR.EP.Q.1	Enable a user to electronically record and display patients' insurance eligibility, and submit insurance eligibility queries to public or private payers and receive an eligibility response in accordance with the applicable standards specified in Table 2A row 4.	

COMPONENT R: ELECTRONIC CLAIMS SUBMISSION

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
R.01	Submit claims electronically to public and private payers in accordance with applicable standards.	Ability to submit claims electronically to public and private payers using applicable standards is demonstrated.		❑ Pass	❑ Fail	IFR.EP.R.1	Enable a user to electronically submit claims to public or private payers in accordance with the applicable standards specified in Table 2A row 4.	

COMPONENT S: PATIENT ELECTRONIC COPY OF HEALTH INFORMATION

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
S.01	Create an electronic copy of a patient's clinical information that includes at a minimum diagnostic test results, problem list, medication lists, medication allergies, immunizations and procedures. Show a print preview of the file. Demonstrate and describe the process to provide the documentation to the patient on electronic media or through other electronic means.	An electronic file is created and includes diagnostic test results, problem list, medication list, medication allergies, immunizations and procedures at a minimum. A print preview shows that the information is in human readable form. The process for providing the electronic copy to the patient is adequately demonstrated and described.		❑ Pass	❑ Fail	IFR.EP.S.1	The system shall provide the ability for a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in human readable format and in accordance with the specified standards, to provide to a patient on electronic media, or through some other electronic means.	If a "print preview" is not available the applicant may email the document to the CCHIT Proctor.

COMPONENT T: PATIENT ELECTRONIC ACCESS TO HEALTH INFORMATION

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
T.01	Demonstrate how a patient can obtain online access to their clinical information including, at a minimum, lab test results, problem list, medication list, medication allergy list, immunizations, and procedures.	A patient user logs in and demonstrates the method to obtain online access to their clinical information including lab test results, problem list, medication list, medication allergy list, immunizations and procedures.		❑ Pass	❑ Fail	IFR.EP.T.1	The system shall provide patients with online access to their clinical information, including, at a minimum, lab test results, problem list, medication list, medication allergy list, immunizations, and procedures.	

COMPONENT V: PATIENT CLINICAL SUMMARY

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
V.01	Create a clinical summary to provide to a patient, either in paper or electronic form, for a specific single office visit (encounter) that includes, at a minimum, diagnostic test results, medication list, medication allergy list, procedures, problem list, and immunizations. If the clinical summary is provided in paper form, show a print preview of the document.	Applicant demonstrates the ability to supply the patient with either a paper or electronic summary of one office visit (encounter), including at a minimum, diagnostic test results, medication list, medication allergy list, procedures, problem list, and immunizations. Print preview is demonstrated if the summary is produced on paper.		❑ Pass	❑ Fail	IFR.EP.V.1	The system shall provide the ability for a user to provide clinical summaries to patients (in paper or electronic form) for each office visit that include, at a minimum, diagnostic test results, medication list, medication allergy list, procedures, problem list, and immunizations.	

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
V.02	If the clinical summary from Step V.02 is provided electronically (i.e., not printed), it must be provided in: 1) human readable format; and 2) in accordance with the specified standards in Table 2A, Row 1 of the IFR.	For electronic summaries, the applicant demonstrates that the document is in human readable form and then demonstrates and describes the process used to transmit the file electronically to the patient following the prescribed standards in Table 2A, Row 1 of the IFR.		❑ Pass	❑ Fail	IFR.EP.V.1	If the clinical summary is provided electronically (i.e., not printed), it must be provided in human readable format; and in accordance with the standards specified. Patient Summary Record: HL7 CDA R2 CCD Level 2 or ASTM CCR: • Problem List: Applicable HIPAA code set required by law (i.e.,ICD-9-CM); or SNOMED CT® •Medication List: Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm+ •Medication Allergy List: No standard adopted at this time. •Procedures: Applicable HIPAA code sets required by law (i.e., ICD-9-CM or CPT-4®) •Vital Signs: No standard adopted at this time. •Units of Measure: No standard adopted at this time. •Lab Orders and Results: LOINC® when LOINC® codes have been received from a laboratory	Standards specified in Table 2A, Row 1 of the IFR for electronic files.

COMPONENT W: EXCHANGE CLINICAL INFORMATION

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
W.01	Receive the CCD file from Proctor. Match the patient summary file to the correct chart in the EHR. Store the file as an intact document in that chart. Display the content of the CCD document. The required display elements are: • Patient Name, Birth Date, and Gender; and • Section labels (title) and associated narrative text for the patient demographics, medication list, immunizations, medication allergy list, problem list, procedures, and diagnostic test results sections.	The CCD file is received and filed in the appropriate chart by matching the patient registration information contained in the document to the appropriate test patient chart in the system The system displays the correct narrative (human readable) information contained in the CCD document. The required display elements are: • Patient Name, Birth Date, and Gender; and • Section labels (title) and associated narrative text for patient demographics, medication list, immunizations, medication allergy list, problem list, procedures, and diagnostic test results.		❑ Pass	❑ Fail	IFR.EP.W.1	Electronically receive a patient summary record, from other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations and procedures and upon receipt of a patient summary record formatted in an alternative standard specified in Table 2A row1, displaying it in human readable format.	The data is structured, exchanged using a standard format, filed (not thrown away), and displayed, but discrete data import is not required. It is acceptable to display calculated age of patient rather than date of birth. For further guidance, see the ***Preliminary ARRA IFR Stage 1 Interoperability Test Guide***.

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
W.02	Receive the ASTM CCR file from the Proctor. Match the patient summary file to the correct chart in the EHR. Store the file as an intact document in that chart. Display the content of the ASTM CCR document. The required display elements are: • Patient Name, Birth Date, and Gender and • Section labels (title) and associated narrative text for the patient demographics, medication list, immunizations, medication allergy list, problem list, procedures, and diagnostic test results sections.	The file is received and filed in the appropriate chart by matching the patient registration information contained in the document to the appropriate test patient chart in the system. The system displays the correct narrative (human readable) information contained in the ASTM CCR document. The required display elements are: • Patient Name, Birth Date, and Gender and • Section labels (title) and associated narrative text for the patient demographics, medication list, immunizations, medication allergy list, problem list, procedures, and diagnostic test results sections.		❑ Pass	❑ Fail	IFR.EP.W.1	Electronically receive a patient summary record, from other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations and procedures and upon receipt of a patient summary record formatted in an alternative standard specified in Table 2A row1, displaying it in human readable format.	The data is structured, exchanged using a standard format, filed (not thrown away), and displayed, but discrete data import is not required. It is acceptable to display calculated age of patient rather than date of birth. For further guidance, see the ***Preliminary ARRA IFR Stage 1 Interoperability Test Guide***.

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
W.03	Applicant will notify the proctor as to what type of patient summary and implementation version (if applicable) will be generated by their system. Before the patient summary document is generated, the CCHIT Proctor will select a pre-existing patient from the system and request the applicant to open the record, verify the demographic information and then add information to the record before creating the document. The updated patient summary is generated by the Applicant and transmitted to the CCHIT Proctor.	Applicant may generate ASTM CCR, CDA R2, or other CCD based documents (including HITSP C32). The following sections of the summary patient record will be updated: medications, immunizations, medication allergies, problem list, procedures, and diagnostic test results. File is validated by CCHIT and contains no xml coding errors, demonstrates correct usage of coded terminologies and vocabularies, and the updated content information is present in the generated document.		❑ Pass	❑ Fail	IFR.EP.W.2	Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations and procedures in accordance with the standards specified in Table 2A row 1.	

COMPONENT X: MEDICATION RECONCILIATION

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
X.01	Demonstrate the ability to electronically complete medication reconciliation of two or more medication lists (compare and merge) into a single medication list that can be electronically displayed in real-time.	Ability to electronically complete medication reconciliation of two or more medication lists (compare and merge) into a single medication list that can be electronically displayed in real-time is demonstrated.		❑ Pass	❑ Fail	IFR.EP.X.1	Electronically complete medication reconciliation of two or more medication lists (compare and merge) into a single medication list that can be electronically displayed in real-time.	

COMPONENT Y: IMMUNIZATION REGISTRIES

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
Y.01	Electronically record and retrieve immunization information. Create a data file containing immunization information using one of the approved standard formats (HL7 2.3.1 or HL7 2.5.1) and submit the file to the CCHIT Proctor for validation.	Ability to electronically record and retrieve immunization information is demonstrated. Ability to create a data file containing immunization information using one of the approved standard formats (HL7 2.3.1 or HL7 2.5.1) is demonstrated, and file is validated by CCHIT staff.		❑ Pass	❑ Fail	IFR.EP.Y.1	Electronically record, retrieve, and transmit immunization information to immunization registries in accordance with the standards specified in Table 2A row 8 or in accordance with the applicable state-designated standard format (HL7 2.3.1 or HL7 2.5.1).	

COMPONENT Z: REPORTABLE LAB SUBMISSION (Not applicable to this domain)

Procedure	Expected Result	Actual Result	Pass/Fail	Criteria and Reference	Comments

COMPONENT AA: ELECTRONIC SYNDROMIC SURVEILLANCE

Procedure		Expected Result	Actual Result	Pass/Fail		Criteria and Reference		Comments
AA.01	Record a diagnosis of influenza for a patient of your choosing. Create a data file compiling all patients with reported diagnosis of influenza. Verify that patient and diagnosis that was just added at this step are present in the file. Format the file for submission to a public health organization using one of the approved standard formats (HL7 2.3.1 or HL7 2.5.1) and submit the file to the CCHIT Proctor for validation.	Diagnosis of influenza is captured in the EHR for the specified patient. Data file of all patients with influenza contains specified patient and diagnosis. Data file is successfully validated as meeting one of the required acceptable standard formats (HL7 2.3.1 or HL7 2.5.1).		❑ Pass	❑ Fail	IFR.EP.AA.1	Electronically record, retrieve, and transmit syndrome-based (e.g., influenza like illness) public health surveillance information to public health agencies in accordance with the standards specified in Table 2A row 7 (HL7 2.3.1 or HL7 2.5.1).	