Test protocol for Sending a

ConditionList

2024-11-15

The test protocol relates to the following standard:

|  |  |  |  |
| --- | --- | --- | --- |
| Standard’s name ENG | Standard’s name DK | **Version** | **Type** |
| Standard: ConditionList | Diagnoseoversigt | 1.0.0 | HL7 FHIR |

|  |  |  |  |
| --- | --- | --- | --- |
| **Versioning** | | | |
| **Version** | **Initials** | **Date** | **Description** |
| **1.0.0** | **RCH/TMS/SKS** | **15-11-2024** | **First version of test protocol** |
|  |  |  |  |

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# Introduction

This is a test protocol for Sending a ConditionList.

All documentation concerning ConditionList (see [Background material](#_Baggrundsmaterialer_1)) will be the subject of testing, and the test protocol can be updated to reflect the requirements in the best way possible.

Versioning of the test protocol will follow the major- and minor-version of the standard but may have a patch version that is different from the standard’s patch-version.

The ConditionList is a FHIR document that will be shared over the national service platform (NSP) for document exchange on-demand. The vendor must expect to be tested in IHE-XDS-metadata, to ensure that the document is delivered with correct metadata. A link for this test protocol can be found under [Background material](#_Baggrundsmaterialer_1). The subject of this test will be PLSP (Primærsektorens Leverandør Service Platform), as they create the documents being shared.

Throughout this test protocol, the term ‘Diagnosis Card’ will be used. It refers to the diagnoses selected by the patient’s general practitioner in the GPs system. The diagnoses being shared will be exchanged using the MedCom ConditionList standard and can be seen in receiver systems by the citizen and health care professionals.

When the terms “sender” is used in the test protocol, it refers to PLSP, since it is PLSP that is responsible for sending a MedCom ConditionList.

## Purpose

The test protocol forms the basis for the tests, which must ensure that SUT complies with the established rules and requirements for the standard. The test protocol also forms the basis for the self-test that vendor carries out prior to a live test.

## Prerequisites for live test

Testing is performed by both the Danish Health Data Agency (Danish: Sundhedsdatastyrelsen) and MedCom. A description of the entire test setup, can be found on NSPOP, see [Background material](#_Baggrundsmaterialer_1).

The following prerequisites must be met prior to the live test:

1. The vendor has read the following standard documentation:
   * [Clinical guidelines for application](#_Baggrundsmaterialer_1)
   * [Use cases](#_Baggrundsmaterialer_1)
   * [Implementation Guide](#_Baggrundsmaterialer_1)
   * [Governance](#_Baggrundsmaterialer_1)
   * And other relevant materials, cf. the [background material](#_Baggrundsmaterialer_1).
2. The vendor has performed [self-test](#_Dokumentation_af_egentest), approved by MedCom.
3. The vendor has created the [relevant test persons](#_Testeksempler_og_testpersoner) in system under test (SUT).
4. The tester is expected to be able to choose input data corresponding to the requirements of the test step.
5. The vendor uses the same version of SUT during self-test and live test.
6. Approval requires that the SUT is approved for sending FHIR-Acknowledgement (DK: Kvittering).

## Documentation of self-test

**Self-test**

**Prior to the test, the vendor must have performed self-test, including successfully completed TouchStone self-tests, which are approved by MedCom.**

The self-test is documented by the vendor completing this test protocol.

For self-tests, only the following column must be completed by the vendor:

* [Current result]: is filled in with the results of the self-test and relevant descriptions.

Other columns are reserved for MedCom.

**During the self-test the vendor must document the test results by saving relevant files and screen dumps, and subsequently send these in a combined ZIP file (together with the completed test protocol) to** [**fhir@medcom.dk**](mailto:fhir@medcom.dk)**.**

Alle filer og skærmdumps skal navngives med:

* Standard name
* The number of the relevant test step
* Consecutive letter
* File type

Eksempel: [ENG-navn] \_3.4\_A.xml or [ENG-navn]\_2.2\_B.png

## Background materials

| **Name** | **Version[[1]](#footnote-2)** | **Link/reference** | **Description** |
| --- | --- | --- | --- |
| ConditionList Documentation site |  | <https://medcomdk.github.io/dk-medcom-conditionlist/> | Documentation site with references to all relevant documentation, including:   * Clinical guidelines for application * Use cases * Technical specifications |
| Implementation Guide | 1.0.X | <http://medcomfhir.dk/ig/conditionlist> | Defing MedCom FHIR ConditionList (Danish: Diagnoseoversigt) in document-based exchange of condition lists (Danish: diagnoseoversigt) in the Danish healthcare system. |
| FHIR Documents | 1.0.X | <http://medcomfhir.dk/ig/document> | Describing the use of FHIR in document based exchange of data in Danish healthcare. |
| IHE-XDS-metadata testprotocols |  | <https://svn.medcom.dk/svn/releases/Standarder/IHE/Testprotokol/> | Valid for every type of document exchanged over the [national service platform (NSP)](https://www.nspop.dk/display/Web3/Introduktion+til+NSP-platformen). |
| NSPOP testing |  | <https://www.nspop.dk/display/ESP/Test+af+diagnosedeling> | Information about End-2-End test at the Danish Health Data Authority (da: Sundhedsdatastyrelsen). |
| SOP for MedCom’s test and certification |  | <http://svn.medcom.dk/svn/qms/Offentlig/SOPer/SOP-7.2-MedComs%20test%20og%20certificering_godkendelse.docx> | Description of test and certification of MedCom standards and other tests courses. |

## Test examples and test persons

|  |  |  |
| --- | --- | --- |
| **Name** | **Link/reference** | **Description** |
| Overview of the test persons. | <https://www.medcom.dk/opslag/koder-tabeller-ydere/tabeller/nationale-test-cpr-numre> | Overview of national test personal identification number (DK:CPR-nummer), that can be used during test, if relevant. |

## Test tool

|  |  |  |
| --- | --- | --- |
| **Navne** | **Link/reference** | **Description** |
| FHIR-server with MedCom profiles | <https://fhir.medcom.dk/> | Public server that validates against MedCom's FHIR profiles. It is permitted to use the server for testing the upload/download of FHIR resources. |
| TouchStone | <https://touchstone.aegis.net/touchstone/> | Test tool for testing the FHIR standard.  The vendor can get access to TouchStone as an organisation - either through a license that MedCom supplies (inquiry at [fhir@medcom.dk](mailto:fhir@medcom.dk)), or a license that the supplier has acquired itself.  Find [instructions for TouchStone](https://medcomdk.github.io/MedComLandingPage/assets/documents/TouchStoneGettingStarted.html) here |
| TouchStone test scripts | Link will be provided when ready. | Test scripts relevant for the standard.  Find [instructions for TouchStone](https://medcomdk.github.io/MedComLandingPage/assets/documents/TouchStoneGettingStarted.html) here |

## Test Result

The result for each test step is categorised based on the table below:

| **Marking** | **F1** | **F2** | **F3** | **F4** | **Ok** | **Not relevant** |
| --- | --- | --- | --- | --- | --- | --- |
| **Evaluation** | **Critical** | **Serious** | **Significant** | **Less significant** | **Approved** | **Not an error** |

To get the test and certification approved, the test protocol must consist exclusively of [F4] as well as [OK] results. All [F1], [F2] and [F3] must, therefore, be fixed prior to final approval.

Approval requires that SUT is approved for receiving FHIR Acknowledgement (DK: Kvittering)

For further information, please read [MedCom’s test og certification](#_Baggrundsmaterialer_2).

# Vendor, system under test (SUT) and test result information

## Information about the vendor

This table must be completed by **the vendor** prior to the test.

|  |  |
| --- | --- |
| Company | Completed by vendor |
| Address | Completed by vendor |
| Contact person | Completed by vendor |
| Telephone | Completed by vendor |
| E-mail | Completed by vendor |

## Information about system under test (SUT)

This table must be completed by **the vendor** prior to the test.

|  |  |
| --- | --- |
| System | Completed by vendor |
| Version | Completed by vendor |
| Description | Completed by vendor |
| Test type | Self-test  Final test/certification |

## Information about the test result

Note: This table must be completed by MedCom when the test has been completed.

|  |  |
| --- | --- |
| Test date | 2022-12-31 |
| Test location |  |
| Approved | Yes  No |
| Remarks | Completed by MedCom |
| Carried out by | The name of the fsdMedCom responsible (initials) for this test |

# The test

This section describes the requirements which SUT must meet before final approval.

The test is divided into three sections:

1. Test of TouchStone testscripts
2. Test of requirements for content and flow/workflows, including received receipts
3. Test of technical requirements

Test participants will be asked to complete tests as described in the tables.

## Documentation of the test

**Documentation of the test**

As valid documentation, the test participant or test manager must document completion by continuous screen dumps (.png/.jpeg) and/or files/log files (.xml/.json). **Before the test, it is agreed who is responsible for this.**

The following applies:

* The files must be viewable in a standard tool and must not require further processing by MedCom
* All files and screen dumps must be named with:
  + Standard name
  + The number of the relevant test step
  + Consecutive letter
  + File type

Example: [ENG-navn]\_3.4\_A.xml or [ENG-navn]\_2.2\_B.png

If the vendor has documented the test themselves, the files must be sent in a ZIP file to [fhir@medcom.dk](mailto:fhir@medcom.dk).

## Test of TouchStone testscripts

The purpose of these tests is to ensure that, SUT generates ConditionList technically correct and complies with the rules in the [Implementation Guiden](#_Baggrundsmaterialer).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Test step #** | **Action** | **Test data/test person** | **Expected result** | **Actual result** | **MedCom assessment** |
|  | Run all test scripts for use cases and user flows in TouchStone. |  | All test scripts completed without errors. |  | Choose |

## Test of requirements for content and flow/workflows

The purpose of these tests is to ensure that the standard is implemented with a satisfactory quality, i.e. that implementation meets the business requirements for flow and content as described in the [clinical guidelines for application](#_Baggrundsmaterialer)  and [use case-material](#_Baggrundsmaterialer)s. These test steps are predominantly targeted testing of the user interface.

The table below reflects the use cases that are tested in relation to content and flow/workflows.

|  |  |  |
| --- | --- | --- |
| [**Use case**](#_Baggrundsmaterialer_2) | **Description** | **Section** |
| S1(1) | User actor registers one new diagnosis that is added to the Diagnosis Card | 3.3.1 |
| S1(2) | User actor registers multiple new diagnoses that are added to the Diagnosis Card | 3.3.2 |
| S1(3) | User actor registers new diagnoses that are not allowed to be shared in a ConditionList | 3.3.3 |
| S1(4) | User actor updates one existing diagnosis in the Diagnosis Card | 3.3.4 |
| S1(5) | User actor updates multiple existing diagnoses in the Diagnosis Card | 3.3.5 |
| S1(6) | User actor deletes one diagnosis from the Diagnosis Card | 3.3.6 |
| S1(7) | User actor deletes all diagnoses from the Diagnosis Card | 3.3.7 |

*Tabel 1: Overview table of use cases, being tested*

### S1(1): User actor registers one new diagnosis that is added to the Diagnosis Card

| **Test step #** | **Action** | **Test data** | **Expected result** | **Actual result** | **MedCom assessment** |
| --- | --- | --- | --- | --- | --- |
|  | Sender has access to the patient’s Diagnosis Card. |  | Sender has access to the patient’s Diagnosis Card. |  | Choose |
|  | The patient has a diagnosis (no. 1) with the following information (Considered a maximum example of a diagnosis):   * ICPC-2 and SKS-D codes, including code, system, and if available, display value. * A text (DA: diagnosetekst). It must be a text that is explicit chosen by the general ractitioner (GP) and it must be different from the two codes. * Diagnosis status (category:status) = current (DA: Aktuel) * Diagnosis type (category:type) = encounter-diagnosis (DA: kontaktdiagnose) * Date and time of diagnosis onset (DA: debutdato) * Date and time of registration in the GP’s system (DA: Registreringsdato) * Date and time of abatement (DA: afslutningsdato) * clinicalStatus = resolved * A note (DA: tillægstekst) |  | The listed information are added for a diagnosis in the patient‘s Diagnosis Card. |  | Choose |
|  | Create a valid ConditionList document based on the diagnosis added in the test steps above. |  | A valid ConditionList document is created. |  | Choose |
|  | Show that clinicalStatus is always added automatically when date and time of abatement (DA: afslutningsdato) is included in a condition. Code ´resolved´ is recommended. |  | ClinicalStatus is always added automatically when date and time of abatement (DA: afslutningsdato) is included in a condition. Code ´resolved´ is recommended. |  | Choose |
|  | Show that the last updated time (Composition.date) and time of bundle assemblement (Bundle.timestamp) is correct.  **Note**: The Composition.date is the last update date of the condition list performed by the patient's GP, and Bundle.timestamp is the time the bundle was assembled |  | Last updated time (Composition.date) and time of bundle assemblement (Bundle.timestamp) is correct. |  | Choose |
|  | Save relevant screenshots and files. |  | Relevant screenshots and files are saved. |  | Choose |

### S1(2): User actor registers multiple new diagnoses that are added to the Diagnosis Card

| **Test step #** | **Action** | **Test data** | **Expected result** | **Actual result** | **MedCom assessment** |
| --- | --- | --- | --- | --- | --- |
|  | *(Continue to work with on same Diagnosis Card as in S1(1))* The patient has a new diagnosis (no. 2) with the following information:   * ICPC-2 and SKS-D codes, including code, system, and if available, display value. * A text (DA: diagnosetekst) * Diagnosis status (category:status) = resolved (DA: Relevant) * Diagnosis type (category:type) = Problem-list-item (DA: forløbsdiagnose) * Date and time of registration in the GP’s system (DA: Registreringsdato) |  | The listed information are added for a new diagnosis in the patient‘s Diagnosis Card. |  | Choose |
|  | The patient has a new diagnosis (no. 3) with the following information (considered a minimum example of a diagnosis without missing data):   * An SKS-D code, including code, system, and if available, display value. * A text (DA: diagnosetekst) * Diagnosis status (category:status) = resolved (DA: Relevant) * Date and time of registration in the GP’s system (DA: Registreringsdato) |  | The listed information are added for a new diagnosis in the patient‘s Diagnosis Card. |  | Choose |
|  | Create a valid ConditionList document based on the diagnoses added in the test steps above. |  | A valid ConditionList document is created. |  | Choose |
|  | Save relevant screenshots and files. |  | Relevant screenshots and files are saved. |  | Choose |

### S1(3): User actor registers new diagnoses that are not allowed to be shared in a ConditionList

| **Test step #** | **Action** | **Test data** | **Expected result** | **Actual result** | **MedCom assessment** |
| --- | --- | --- | --- | --- | --- |
|  | *(Continue to work on the same Diagnosis Card as in S1(2))*  Add a new diagnosis (no. 4) without a diagnosis status (category:status). |  | The new diagnosis is added in the patient‘s Diagnosis Card. |  | Choose |
|  | If possible, add a new diagnosis (no. 5) with a status different from resolved and current. |  | The new diagnosis is added in the patient‘s Diagnosis Card. |  | Choose |
|  | Create a valid ConditionList document based on the diagnoses added in the test steps above. |  | A valid ConditionList document is created. Diagnosis 4 and 5 are not included in the document, cf. business rule 1 (DA: forretningsregel 1): <https://www.nspop.dk/display/ESP/Indhold+og+forretningsregler+Diagnoser>. |  | Choose |
|  | Save relevant screenshots and files. |  | Relevant screenshots and files are saved. |  | Choose |

### S1(4): User actor updates one existing diagnosis in the Diagnosis Card

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Test step #** | **Action** | **Test data** | **Expected result** | **Actual result** | **MedCom assessment** |
|  | *(Continue to work on the same Diagnosis Card as in S1(3))*  Update the diagnosis status (category:status) for diagnosis no. 1 from current (DA: Aktuel) to resolved (DA: Relevant). |  | Diagnosis status has been updated correctly. |  | Choose |
|  | Create a valid ConditionList document. |  | A valid ConditionList document is created and it includes the updated status. |  | Choose |
|  | Compare last updated time (Composition.date) and time of bundle assemblement (Bundle.timestamp) with the generated document in S1(3) and show that both timestamps have been updated. |  | Composition.date and Bundle.timestamp have been updated. |  | Choose |
|  | Save relevant screenshots and files. |  | Relevant screenshots and files are saved. |  | Choose |

### S1(5): User actor updates multiple existing diagnoses in the Diagnosis Card

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Test step #** | **Action** | **Test data** | **Expected result** | **Actual result** | **MedCom assessment** |
|  | *(Continue to work on the same Diagnosis Card as in S1(4))*Update the following:  Diagnosis no. 1:   * ICPC-2 code, including code, system, and if available, display value. * Diagnosis status (category:status) = current (DA: Relevant) * A text (DA: diagnosetekst) * Date and time of diagnosis onset (DA: debutdato) * Date and time of registration in the GP’s system (DA: Registreringsdato) * Date and time of abatement (DA: afslutningsdato) * A note (DA: tillægstekst)   Diagnosis no. 2:   * SKS-D code, including code, system, and if available, display value. * Diagnosis status (category:status) * Diagnosis type (category:type) * Date and time of registration in the GP’s system (DA: Registreringsdato) |  | All elements have been updated correctly. |  | Choose |
|  | Create a valid ConditionList document. |  | A valid ConditionList document is created and it includes all the updated elements. |  | Choose |
|  | Compare last updated time (Composition.date) and time of bundle assemblement (Bundle.timestamp) with the generated document in S1(4) and show that it has been updated correctly. |  | Composition.date and Bundle.timestamp have been updated correctly. |  | Choose |
|  | Save relevant screenshots and files. |  | Relevant screenshots and files are saved. |  | Choose |

### S1(6): User actor deletes one diagnosis from the Diagnosis Card

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Test step #** | **Action** | **Test data** | **Expected result** | **Actual result** | **MedCom assessment** |
|  | *(Continue to work on the same Diagnosis Card as in S1(5))*  Delete diagnosis no. 1 from the patient’s diagnosis card. |  | Diagnosis no. 1 is deleted. |  | Choose |
|  | Create a valid ConditionList document. |  | A valid ConditionList document is created and it does not include diagnosis no. 1. |  | Choose |
|  | Save relevant screenshots and files. |  | Relevant screenshots and files are saved. |  | Choose |

### S1(7) User actor deletes all diagnoses from the Diagnosis Card

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Test step #** | **Action** | **Test data** | **Expected result** | **Actual result** | **MedCom assessment** |
|  | *(Continue to work on the same Diagnosis Card as in S1(6))*  Delete all diagnoses from the patient’s diagnosis card. |  | All diagnoses are deleted. |  | Choose |
|  | Explain or show how SUT ensures that no ConditionList document can be generated. |  | No ConditionList document is created. |  | Choose |
|  | Save relevant screenshots and files. |  | Relevant screenshots and files are saved. |  | Choose |

## Test of general technical requirements

The purpose of these test steps is to ensure that the technical receipt of ConditionList is implemented with satisfactory quality, i.e. supports governance for message communication at a general level, as well as governance for ConditionList as described in 1.4.

### Document format

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Test step #** | **Action** | **Test data** | **Expected results** | **Actual result** | **MedCom assessment** |
|  | **Format**:  Describe which format, XML and/or JSON, the documents are created in. |  | According to agreement with PLSP, the documents will be generated in JSON. |  | Choose |

### Documents with missing content or other code systems/scenarios

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Test step #** | **Action** | **Test data** | **Expected results** | **Actual result** | **MedCom assessment** |
|  | Add a diagnosis (no. 6) with ONLY:   * Diagnosis status (category:status) * Date and time of registration in the GP’s system (DA: Registreringsdato) |  | The diagnosis is added correctly. |  | Choose |
|  | Create a valid ConditionList document. |  | A valid ConditionList document is created. |  | Choose |
|  | Update diagnosis no. 6 to ONLY contain:   * An SKS-D code, including code, system, and if available, display value. * Diagnosis status (category:status) * Date and time of registration in the GP’s system (DA: Registreringsdato) |  | The diagnosis is updated correctly. |  | Choose |
|  | Create a valid ConditionList document. |  | A valid ConditionList document is created. |  | Choose |
|  | Update diagnosis no. 6 to ONLY contain:   * An ICPC-2 code including code, system, but without display value * A text (DA: diagnosetekst) * Diagnosis status (category:status) * Date and time of registration in the GP’s system (DA: Registreringsdato) |  | The diagnosis is updated correctly. |  | Choose |
|  | Create a valid ConditionList document. |  | A valid ConditionList document is created. |  | Choose |
|  | Update diagnosis no. 6 to ONLY contain:   * A text (DA: diagnosetekst) * Date and time of diagnosis onset (DA: debutdato) * Diagnosis status (category:status) * Date and time of registration in the GP’s system (DA: Registreringsdato) |  | The diagnosis is updated correctly. |  | Choose |
|  | Create a valid ConditionList document. |  | A valid ConditionList document is created. |  | Choose |
|  | Update diagnosis no. 6 to ONLY contain:   * A code from another system – e.g. SNOMED-CT * Diagnosis status (category:status) * Date and time of registration in the GP’s system (DA: Registreringsdato) |  | The diagnosis is updated correctly. |  | Choose |
|  | Create a valid ConditionList document. |  | A valid ConditionList document is created. |  | Choose |
|  | Update diagnosis no. 6 to ONLY contain:   * A code without a code system and without display value * Diagnosis status (category:status) * Date and time of registration in the GP’s system (DA: Registreringsdato) |  | The diagnosis is updated correctly. |  | Choose |
|  | Create a valid ConditionList document. |  | A valid ConditionList document is created. |  | Choose |
|  | Demonstrate and/or explain how SUT is designed so that a Condition.category:status.code.display value is never used as the Condition.category.text value. |  | SUT is designed so that a Condition.category:status.code.display value is never used as the Condition.category.text value. |  | Choose |
|  | Save relevant screenshots and files. |  | Relevant screenshots and files are saved. |  | Choose |

### General document content

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Test step #** | **Action** | **Test data** | **Expected results** | **Actual result** | **MedCom assessment** |
|  | Use the ConditionList document created in teststep 3.3.5.2 and validate it. |  | The ConditionList document created in teststep 3.3.5.2 is valid. |  | Choose |
|  | **MedComConditionListBundle:**  Demonstrate that Bundle.id and Bundle.identifier are different. Bundle.identifier must be a newly generated version 4 UUIDs. |  | Bundle.id and Bundle.identifier are different and Bundle.identifier is included correctly as newly generated version 4 UUIDs. |  | Choose |
|  | Demonstrate that Bundle.type = document |  | Bundle.type = document |  | Choose |
|  | Demonstrate that the first element included in Bundle.entry is a resource of type Composition, which obeys MedComConditionListComposition. |  | The first element included in Bundle.entry is a resource of type Composition. |  | Choose |
|  | Demonstrate that all the included resources must be referenced from the Bundle.entry element, including entry.fullUrl and entry.resource. |  | All included resources are referenced from the Bundle.entry element correctly. |  | Choose |
|  | **MedComConditionListComposition:**  Demonstrate that Composition.author:institution is included and is of type MedComConditionListOrganization.  **Note**: it is optional to include a Composition.author:institution of the type MedComDocumentPractitioner |  | author:institution is included and is of type MedComConditionListOrganization. |  | Choose |
|  | Composition.section.entry must reference one MedComConditionListConditions for each included diagnosis. |  | Only MedComConditionListCondition is referenced. |  | Choose |
|  | Demonstrate that Composition.confidentiality.code is “N”. |  | Composition.confidentiality is “N” |  | Choose |
|  | Demonstrate that Composition.meta.profile includes the canonical URL for the profile: <http://medcomfhir.dk/ig/conditionlist/StructureDefinition/medcom-conditionlist-composition> |  | Composition.meta.profile includes the canonical URL for the correct profile. |  | Choose |
|  | Composition.title must be (in Danish) "Diagnoseoversigt for 'CPR-nummer'", where 'CPR-nummer' is the actual identifier for the patient (Patient.identifier.value). |  | Composition.title is "Diagnoseoversigt for 'CPR-nummer'”. |  | Choose |
|  | Demonstrate that Composition.status is “final” |  | Composition.status is “final” |  | Choose |
|  | Composition.type must be the LOINC code "11450-4” and display-value ”Problem List". |  | Composition.type is the correct LOINC system, code and display value. |  | Choose |
|  | Demonstrate that Composition.language is “da” for Danish. |  | Composition.language is “da” |  | Choose |
|  | Demonstrate that Composition.subject is a reference to the test patient and that it is of type MedComDocumentPatient. |  | Composition.subject is a reference to the test patient and is of type MedComDocumentPatient. |  | Choose |
|  | Demonstrate that a narrative is included for the Composition resource. |  | A narrative is included for the Composition resource correctly. |  | Choose |
|  | Demonstrate that a narrative is included for each Composition.section.text in the Composition resource. |  | A narrative is included for each Composition.section.text in the Composition resource. |  | Choose |
|  | **MedComDocumentPatient**:  Demonstrate that the patient’s Danish CPR-number is included correctly. |  | identifier:cpr.system has fixed value urn:oid:1.2.208.176.1.2 and identifier:cpr.value is a cpr-number in 10 digits. |  | Choose |
|  | Demonstrate that the following elements are included correctly:   * name.family * name.given * gender * birthDate |  | The elements are included correctly. |  | Choose |
|  | Demonstrate that a narrative is included for the Patient resource. |  | A narrative is included for the Patient resource correctly. |  | Choose |
|  | Save relevant screenshots and files. |  | Relevant screenshots and files are saved. |  | Choose |
|  | If the system supports it, demonstrate that a Composition.attester can be included and that Composition.attester.mode uses the Value Set http://hl7.org/fhir/ValueSet/composition-attestation-mode. |  | A Composition.attester can be included and Composition.attester.mode uses the Value Set http://hl7.org/fhir/ValueSet/composition-attestation-mode. |  | Choose |

1. X expresses patch-level versioning, which includes minor fixes that are backward compatible. [↑](#footnote-ref-2)