Test Data for §170.314(b)(2) Transitions of care – create and transmit summary care records

Test data provided for public comment are samples and will be updated when the test procedures are finalized. Test data are provided to ensure that the functional and interoperability requirements identified in the criterion can be adequately evaluated for conformance, as well as to provide consistency in the testing process across multiple ATLs. The provided test data focus on evaluating the basic capabilities of required EHR technology, rather than exercising the full breadth/depth of capability that installed EHR technology might be expected to support. The test data are formatted for readability of use within the testing process. The format is not prescribing a particular end-user view or rendering. No additional requirements should be drawn from the format.

The Tester shall use and apply the provided test data during the test, without exception, unless one of the following conditions exists:

- The Tester determines that the Vendor product is sufficiently specialized that the provided test data needs to be modified in order to conduct an adequate test. Having made the determination that some modification to the provided test data is necessary, the Tester shall record the modifications made as part of the test documentation.
- The Tester determines that changes to the test data will improve the efficiency of the testing process; primarily through using consistent demographic data throughout the testing workflow. The Tester shall ensure that the functional and interoperable requirements identified in the criterion can be adequately evaluated for conformance and that the test data provides a comparable level of robustness.

Any departure from the provided test data shall strictly 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 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 verifies that the test data are entered correctly as specified in the test procedure.

TD170.314.b.2 - Ambulatory

This document contains a sample of test data to be used as an illustration of 170.314(b)(2) in the ambulatory setting. The data contained within this document is intended to provide a patient record to be formatted according to the Consolidated CDA and transmitted.

To exemplify 170.314(b)(2), the following clinical scenario will be employed. Mr. John Williams is a 65-year-old black male with a history of type II diabetes and hypercholesterolemia controlled on NovoLog, Lantus, and Lipitor. He presented to Dr. Samir Khan at Family Health Clinic on September 20, 2012 with a one day history of sharp chest pain, exacerbated by movement, tender to touch, but better with rest. Mr. Williams was diagnosed by Dr. Khan with costochondritis. He was instructed to take over-the-counter analgesic medication as needed and was referred to Dr. Jason Price for an endocrinology consultation.

A) Demographics and Care Team

Name	Sex	Date of Birth	Race	Ethnicity	Preferred Language	Home Address	Care Team Members
John Williams	M	4/7/1947	Black	Not Hispanic or Latino	English	55 Center Avenue Apt 2B, Phoenix, AZ 85002	Provider – Dr. Samir Khan

B) Encounter Information

Provider Name	Provider Office Contact	Date of Visit	Visit Location
Dr. Samir Khan	Holly Liu Tel:604-555-2233	9/20/2012	Family Health Clinic 99 Center Avenue Phoenix, AZ 85002

C) Medication Allergies

Code	CodeSystem	Allergy Substance	Reaction	Severity	Status
7982	RxNorm	Penicillin G benzathine	Hives	***Select*** **(Moderate, Severe)**	Active
2670	RxNorm	Codeine	Nausea	***Select*** **(Mild, Moderate)**	Active

D) Medications

Code	CodeSystem	Medication	Start Date	Route	Dose	Status	Fill Instructions
284810	RxNorm	NovoLog	1/9/2009	Sub-cutaneous	***Select* (15, 20, 25)** units, three times daily before meals	Active	Generic substitution allowed
261551	RxNorm	Lantus	1/9/2009	Sub-cutaneous	***Select* (30, 40, 50)** units, once daily before sleep	Active	Generic substitution allowed
617320	RxNorm	Lipitor	8/8/2008	Oral	***Select* (10, 20, 40)** mg tablet, once daily	Active	Generic substitution allowed

E) Problems

Code	CodeSystem	Problem Name	Start Date	End Date	Status
64109004	SNOMED-CT	Costochondritis	9/20/2012	-	Active
190424003	SNOMED-CT	Type II Diabetes	1/9/2009	-	Active
13644009	SNOMED-CT	Hypercholesterolemia	8/8/2008	-	Active

F) Procedures

Code	CodeSystem	Procedure Name	Target Site	Date of Procedure
142008000	SNOMED-CT	EKG	-	9/20/2012

G) Vital Signs

Vitals	Date	Value
Height	9/20/2012	178 cm
Weight	9/20/2012	81 kg
Blood Pressure	9/20/2012	***Select* (140-160)/*Select* (90-100)** mmHg
BMI	9/20/2012	25.6

H) Laboratory Values/ Results

Test Code	Code System	Name	Actual Result	Date
2947-0	LOINC	Na	***Select* (135-145)** mmol/L	9/20/2012
6298-4	LOINC	K	***Select* (3.5-5.1)** mmol/L	9/20/2012
2069-3	LOINC	Cl	***Select* (95-110)** mmol/L	9/20/2012
1959-6	LOINC	HCO3	***Select* (23-29)** mmol/L	9/20/2012
6299-2	LOINC	BUN	***Select* (8-24)** mg/dL	9/20/2012
38483-4	LOINC	Cr	***Select* (0.8-1.3)** mg/dL	9/20/2012
2339-0	LOINC	Glu	***Select* (185-205)** mg/dL	9/20/2012

I) Care Plan, Goals, and Instructions (Examples and sample format provided; Vendor-supplied data that includes care plan goals and instructions is permitted.)

Goal	Instructions
Smoking cessation	Resources and instructions provided during visit
Weight loss	Diet and exercise counseling provided during visit

J) Social History

Element Description	Description	Start Date	End Date	Code	Code System
Smoking Status	Never smoker	-	-	266919005	SNOMED-CT

K) Immunizations or Immunizations Administered during visit

Vaccine Code	CodeSystem	Vaccine Name	Date	Status
88	CVX	Influenza virus vaccine	9/20/2012	Completed

L) Encounter Diagnosis

Code	Code System	Description	Date	Finding	Finding Code
99213	SNOMED-CT	Ambulatory Visit	9/20/2012	Costochondritis	64109004

M) Cognitive and Functional Status

Cognitive Condition	Code	Code System	Date	Status
Memory impairment	386807006	SNOMED-CT	9/20/2012	Active

Functional Condition	Code	Code System	Date	Status
Dependence on Walking Stick	105504002	SNOMED-CT	920/2012	Active

L) Referral

Reason for Referral	Provider	Office Contact	Location
Type II Diabetes Management	Dr. Jason Price	Wendy Flower Tel:604-555-4455	Family Health Clinic 99 Center Avenue Phoenix, AZ 85002

TD170.314.b.2 – Inpatient Discharge

This document contains a sample of test data to be used as an illustration of 170.314(b)(2) in the inpatient setting. The data contained within this document is intended to provide a patient record to be formatted according to the Consolidated CDA and transmitted from an inpatient setting to an ambulatory setting.

To exemplify 170.314(b)(2), the following clinical scenario will be employed. Mr. John Williams is a 65-year-old black male with a history of type II diabetes and hypercholesterolemia controlled on NovoLog, Lantus, and Lipitor. He presented to the emergency department at Local Community Hospital on October 2, 2012 with a two hour history of crushing chest pain radiating to his left arm, which began immediately after vigorous exercise. Mr. Williams underwent an EKG which demonstrated no abnormalities. He was admitted, underwent serial troponins, and was discharged on hospital day #2 with instructions to follow up with his primary care physician.

A) Demographics and Care Team

Name	Sex	Date of Birth	Race	Ethnicity	Preferred Language	Home Address	Care Team Members
John Williams	M	4/7/1947	Black	Not Hispanic or Latino	English	55 Center Avenue Apt 2B, Phoenix, AZ 85002	Provider – Dr. Sanjay Kumar

B) Encounter Information

Admission Date	Admission Location	Discharge Date	Discharge Location
10/2/2012	Local Community Hospital 77 Center Avenue Phoenix, AZ 85002	10/3/2012	Local Community Hospital 77 Center Avenue Phoenix, AZ 85002

C) Medication Allergies

Code	CodeSystem	Allergy Substance	Reaction	Severity	Status
7982	RxNorm	Penicillin G benzathine	Hives	***Select*** **(Moderate, Severe)**	Active
2670	RxNorm	Codeine	Nausea	***Select*** **(Mild, Moderate)**	Active

D) Medications

Code	CodeSystem	Medication	Start Date	Route	Dose	Status	Fill Instructions
1191	RxNorm	aspirin	10/2/2012	Oral	81 mg tablet, once daily	Active	Generic substitution allowed

284810	RxNorm	NovoLog	1/9/2009	Sub-cutaneous	***Select* (15, 20, 25)** units, three times daily before meals	Active	Generic substitution allowed
261551	RxNorm	Lantus	1/9/2009	Sub-cutaneous	***Select* (30, 40, 50)** units, once daily before sleep	Active	Generic substitution allowed
617320	RxNorm	Lipitor	8/8/2008	Oral	***Select* (10, 20, 40)** mg tablet, once daily	Active	Generic substitution allowed

E) Problems

Code	CodeSystem	Problem Name	Start Date	End Date	Status
194828000	SNOMED-CT	Angina	10/2/2012	-	Active
190424003	SNOMED-CT	Type II Diabetes	1/9/2009	-	Active
13644009	SNOMED-CT	Hypercholesterolemia	8/8/2008	-	Active

F) Procedures

Code	CodeSystem	Procedure Name	Target Site	Date of Procedure
142008000	SNOMED-CT	EKG	-	10/2/2012

G) Vital Signs

Vitals	Date	Value
Height	10/2/2012	178 cm
Weight	10/2/2012	81 kg
Blood Pressure	10/2/2012	***Select* (140-160)/Select (90-100)** mmHg
BMI	10/2/2012	25.6

H) Laboratory Values/ Results

Test Code	Code System	Name	Actual Result	Date
2947-0	LOINC	Na	***Select* (135-145)** mmol/L	10/2/2012

6298-4	LOINC	K	***Select* (3.5-5.1)** mmol/L	10/2/2012
2069-3	LOINC	Cl	***Select* (95-110)** mmol/L	10/2/2012
2028-9	LOINC	CO2	***Select* (23-29)** mmol/L	10/2/2012
6299-2	LOINC	BUN	***Select* (8-24)** mg/dL	10/2/2012
38483-4	LOINC	Cr	***Select* (0.8-1.3)** mg/dL	10/2/2012
2339-0	LOINC	Glu	***Select* (125-145)** mg/dL	10/2/2012
6598-7	LOINC	Troponin T	0.01 ng/ml	10/2/2012
6598-7	LOINC	Troponin T	0.01 ng/ml	10/3/2012

I) Care Plan, Goals, and Instructions (Examples and sample format provided; Vendor-supplied data that includes care plan goals and instructions is permitted.)

Goal	Instructions
Smoking cessation	Resources and instructions provided during visit
Weight loss	Diet and exercise counseling provided during visit

J) Social History

Element Description	Description	Start Date	End Date	Code	Code System
Smoking Status	Never smoker	-	-	266919005	SNOMED-CT

K) Immunizations or Immunizations Administered during visit

Vaccine Code	CodeSystem	Vaccine Name	Date	Status
88	CVX	Influenza virus vaccine	10/2/2012	Completed

J) Encounter Diagnosis

Code	Code System	Description	Date	Finding	Finding Code
99222	CPT	Inpatient admission	10/2/2012	Angina	194828000

K) Cognitive and Functional Status

Cognitive Condition	Code	Code System	Date	Status
Memory impairment	386807006	SNOMED-CT	10/3/2012	Active

Functional Condition	Code	Code System	Date	Status
Dependence on Walking Stick	105504002	SNOMED-CT	10/3/2012	Active

L) Discharge Instructions

You were admitted to Local Community Hospital on 10/2/2012 with a diagnosis of angina. You underwent an electrocardiogram and had serial troponins drawn. Both tests were normal and your condition improved. You were discharged from Local Community Hospital on 10/3/2012 with instructions to follow up with your primary care provider. Should you have any questions prior to discharge, please contact a member of your healthcare team. If you have left the hospital and have any questions, please contact your primary care physician.

Instructions:

1. Take all medications as prescribed
2. No vigorous exercise
3. If you experience any of the following symptoms, call your primary care physician or return to the Emergency Room:
    a. Chest pain
    b. Shortness of breath
    c. Dizziness or light-headedness
    d. Pain or redness at the site of any previous intravenous catheter
    e. Any other unusual symptoms
4. Schedule a follow up appointment with your primary care physician in one week

TD170.314.b.2 – Inpatient Transfer

This document contains a sample of test data to be used as an illustration of 170.314(b)(2) in the inpatient setting. The data contained within this document is intended to provide a patient record to be formatted according to the Consolidated CDA and transmitted from an inpatient setting to another inpatient setting.

To exemplify 170.314(b)(2), the following clinical scenario will be employed. Mr. John Williams is a 65-year-old black male with a history of type II diabetes and hypercholesterolemia controlled on NovoLog, Lantus, and Lipitor. He presented to the emergency department at Local Community Hospital on October 2, 2012 with a four hour history of crushing chest pain radiating to his left arm. Mr. Williams underwent an EKG which demonstrated inverted T waves in the anterior leads. He was admitted, was started on oxygen therapy, and was given stat doses of aspirin, lisinopril, morphine, and nitroglycerin. He was transferred the same day to a larger facility with a cardiac catheterization lab.

A) Demographics and Care Team

Name	Sex	Date of Birth	Race	Ethnicity	Preferred Language	Home Address	Care Team Members
John Williams	M	4/7/1947	Black	Not Hispanic or Latino	English	55 Center Avenue Apt 2B, Phoenix, AZ 85002	Provider – Dr. Sanjay Kumar

B) Encounter Information

Admission Date	Admission Location	Transfer Date	Transfer Location
10/2/2012	Local Community Hospital 77 Center Avenue Phoenix, AZ 85002	10/2/2012	Local Community Hospital 77 Center Avenue Phoenix, AZ 85002

C) Medication Allergies

Code	CodeSystem	Allergy Substance	Reaction	Severity	Status
7982	RxNorm	Penicillin G benzathine	Hives	***Select*** **(Moderate, Severe)**	Active
2670	RxNorm	Codeine	Nausea	***Select*** **(Mild, Moderate)**	Active

D) Medications

Code	CodeSystem	Medication	Start Date	Route	Dose	Status	Fill Instructions
1191	RxNorm	aspirin	10/2/2012	Oral	325 mg tablet, once	Active	Generic substitution allowed

					stat		
29046	RxNorm	lisinopril	10/2/2012	Oral	5 mg tablet, once stat	Active	Generic substitution allowed
7052	RxNorm	morphine	10/2/2012	IV	4 mg, once stat	Active	Generic substitution allowed
4917	RxNorm	nitroglycerin	10/2/2012	Sub-lingual	0.6 mg, once stat	Active	Generic substitution allowed
284810	RxNorm	NovoLog	1/9/2009	Sub-cutaneous	***Select* (15, 20, 25)** units, three times daily before meals	Active	Generic substitution allowed
261551	RxNorm	Lantus	1/9/2009	Sub-cutaneous	***Select* (30, 40, 50)** units, once daily before sleep	Active	Generic substitution allowed
617320	RxNorm	Lipitor	8/8/2008	Oral	***Select* (10, 20, 40)** mg tablet, once daily	Active	Generic substitution allowed

E) Problems

Code	CodeSystem	Problem Name	Start Date	End Date	Status
57054005	SNOMED-CT	Myocardial infarction, acute	10/2/2012	-	Active
190424003	SNOMED-CT	Type II Diabetes	1/9/2009	-	Active
13644009	SNOMED-CT	Hypercholesterolemia	8/8/2008	-	Active

F) Procedures

Code	CodeSystem	Procedure Name	Target Site	Date of Procedure
142008000	SNOMED-CT	EKG	-	10/2/2012

G) Vital Signs

Vitals	Date	Value
Height	10/2/2012	178 cm
Weight	10/2/2012	81 kg
Blood Pressure	10/2/2012	***Select* (160-180/100-110)** mmHg
BMI	10/2/2012	25.6

H) Laboratory Values/ Results

Test Code	Code System	Name	Actual Result	Date
2947-0	LOINC	Na	***Select* (135-145)** mmol/L	10/2/2012
6298-4	LOINC	K	***Select* (3.5-5.1)** mmol/L	10/2/2012
2069-3	LOINC	Cl	***Select* (95-110)** mmol/L	10/2/2012
1959-6	LOINC	HCO3	***Select* (23-29)** mmol/L	10/2/2012
6299-2	LOINC	BUN	***Select* (8-24)** mg/dL	10/2/2012
38483-4	LOINC	Cr	***Select* (0.8-1.3)** mg/dL	10/2/2012
2339-0	LOINC	Glu	***Select* (125-145)** mg/dL	10/2/2012

I) Care Plan, Goals, and Instructions (Examples and sample format provided; Vendor-supplied data that includes care plan goals and instructions is permitted.)

Goal	Instructions
Smoking cessation	Resources and instructions provided during visit
Weight loss	Diet and exercise counseling provided during visit

H) Social History

Element Description	Description	Start Date	End Date	Code	Code System
Smoking Status	Never smoker	-	-	266919005	SNOMED-CT

I) Immunizations or Immunizations Administered during visit

Vaccine Code	CodeSystem	Vaccine Name	Date	Status
88	CVX	Influenza virus vaccine	10/2/2012	Completed

J) Encounter Diagnosis

Code	Code System	Description	Date	Finding	Finding Code
99222	SNOMED-CT	Inpatient admission	10/2/2012	Myocardial Infarction, Acute	57054005

K) Cognitive and Functional Status

Cognitive Condition	Code	Code System	Date	Status
Memory impairment	386807006	SNOMED-CT	10/2/2012	Active

Functional Condition	Code	Code System	Date	Status
Dependence on Walking Stick	105504002	SNOMED-CT	10/2/2012	Active

L) Discharge Instructions

You were admitted to Local Community Hospital on 10/2/2012 with a diagnosis of an acute heart attack. You underwent an electrocardiogram that showed abnormalities associated with a heart attack. You were treated immediately with oxygen, aspirin, lisinopril, morphine, and nitroglycerin. You were transferred to a larger facility with a cardiac catheterization lab when your condition was stable.

Instructions:

1. Take all medications as prescribed
2. Bed rest
3. If you experience any of the following symptoms, call 911 or return to the Emergency Room:
    f. Chest pain
    g. Shortness of breath
    h. Dizziness or light-headedness
    i. Pain or redness at the site of any previous intravenous catheter
    j. Any other unusual symptoms

4. You will be re-admitted to the receiving hospital and your care will be assumed by the accepting provider