Test Data for §170.314(e)(1) View, Download, and Transmit to a 3rd Party

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.

TD170.314.e.1 - Ambulatory

This document contains a sample of test data to be used as an illustration of 170.314(e)(1) in the ambulatory setting. The data contained within this document is intended to provide a patient record to be viewed, downloaded and transmitted by a patient (or a patient's authorized representative) to a third-party.

To exemplify 170.314(e)(1), the following clinical scenario will be employed. Ms. Mary Grant is a 25-year-old white female with a history of hypothyroidism controlled on Synthroid. She presented to Dr. Martin Green at Family Health Clinic on September 20, 2012 with a two week history of nasal congestion, nasal discharge, facial pain, and intermittent fevers. Ms. Grant was diagnosed by Dr. Green with bacterial sinusitis. She was treated and was referred to Dr. Martin Rodriguez for an otolaryngology consultation.

A) Demographics and Care Team

Name	Sex	Date of Birth	Race	Ethnicity	Preferred Language	Home Address	Care Team Members
Mary Grant	F	3/21/1987	White	Not Hispanic or Latino	English	333 Main Street Apt 3A, Richmond, VA 23222	Provider – Dr. Martin Green

B) Encounter Information

Provider Name	Provider Office Contact	Date of Visit	Visit Location
Dr. Martin Green	Denise Brown Tel:804-555-1122	9/20/2012	Family Health Clinic 444 Main Street Richmond, VA 23222

C) Medication Allergies

Code	CodeSystem	Allergy Substance	Reaction	Severity	Status
7982	RxNorm	Penicillin G benzathine	Hives	Moderate	Active
1191	RxNorm	Aspirin	Nausea	Mild	Active

D) Medications

Code	CodeSystem	Medication	Start Date	Route	Dose	Status	Fill Instructions
2231	RxNorm	cephalexin	9/20/2012	Oral	500 mg tablet, 4 times daily for 10 days	Active	Generic substitution allowed

4493	RxNorm	fluoxetine	11/10/2011	Oral	40 mg tablet, once daily	Active	Generic substitution allowed
224920	RxNorm	Synthroid	4/15/2010	Oral	50 mcg tablet, once daily	Active	Generic substitution allowed

E) Problems

Code	CodeSystem	Problem Name	Start Date	End Date	Status
36971009	SNOMED-CT	Sinusitis	9/20/2012	-	Active
35489007	SNOMED-CT	Depression	11/10/2011	-	Active
40930008	SNOMED-CT	Hypothyroidism	4/15/2010	-	Active

F) Procedures

Code	CodeSystem	Procedure Name	Target Site	Date of Procedure
168731009	SNOMED-CT	Chest X-Ray, PA and Lateral Views	82094008 (Lower Respiratory Tract Structure)	9/20/2012

G) Vital Signs

Vitals	Date	Value
Height	9/20/2012	64 in
Weight	9/20/2012	124 lbs
Blood Pressure	9/20/2012	116/72 mmHg
BMI	9/20/2012	21.3

H) Laboratory Values/ Results

Test Code	Code System	Name	Actual Result	Date
30313-1	LOINC	HGB	12.8 g/dl	9/20/2012
33765-9	LOINC	WBC	17.6 (10^3/ul)	9/20/2012
26515-7	LOINC	PLT	247 (10^3/ul)	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

TD170.314.e.1 – Inpatient

This document contains a sample of test data to be used as an illustration of 170.314(e)(1) in the inpatient setting. The data contained within this document is intended to provide a patient record to be viewed, downloaded and transmitted by a patient (or a patient's authorized representative) to a third-party.

To exemplify 170.314(e)(1), the following clinical scenario will be employed. Ms. Mary Grant is a 25-year-old white female with a history of hypothyroidism controlled on Synthroid. She presented to the emergency department at Local Community Hospital on October 2, 2012 with a four-week history of nasal congestion, nasal discharge, facial pain, and intermittent fevers, without improvement after a two-week course of antibiotics. Ms. Grant underwent a CT scan of her sinuses, which revealed a mass in her left maxillary sinus. She was admitted, underwent biopsy of the mass, and was discharged on post-operative day #3 with instructions to follow up with Dr. Martin Rodriguez in the otolaryngology clinic.

A) Demographics and Care Team

Name	Sex	Date of Birth	Race	Ethnicity	Preferred Language	Home Address	Care Team Members
Mary Grant	F	3/21/1987	White	Not Hispanic or Latino	English	333 Main Street Apt 3A, Richmond, VA 23222	Provider – Dr. Martin Rodriguez

B) Encounter Information

Admission Date	Admission Location	Discharge Date	Discharge Location
10/2/2012	Local Community Hospital 888 Main Street Richmond, VA 23222	10/5/2012	Local Community Hospital 888 Main Street Richmond, VA 23222

C) Medication Allergies

Code	CodeSystem	Allergy Substance	Reaction	Severity	Status
7982	RxNorm	Penicillin G benzathine	Hives	Moderate	Active
1191	RxNorm	Aspirin	Nausea	Mild	Active

D) Medications

Code	CodeSystem	Medication	Start Date	Route	Dose	Status	Fill Instructions
20481	RxNorm	cefepime	10/2/2012	IV	1 gram, every 12 hours	Active	Generic substitution allowed

2231	RxNorm	cephalexin	9/20/2012	Oral	500 mg tablet, 4 times daily for 10 days	Inactive	Generic substitution allowed
4493	RxNorm	fluoxetine	11/10/2011	Oral	40 mg tablet, once daily	Active	Generic substitution allowed
224920	RxNorm	Synthroid	4/15/2010	Oral	50 mcg tablet, once daily	Active	Generic substitution allowed

E) Problems

Code	CodeSystem	Problem Name	Start Date	End Date	Status
36971009	SNOMED-CT	Sinusitis	9/20/2012	-	Active
35489007	SNOMED-CT	Depression	11/10/2011	-	Active
40930008	SNOMED-CT	Hypothyroidism	4/15/2010	-	Active

F) Procedures

Code	CodeSystem	Procedure Name	Target Site	Date of Procedure
241526005	SNOMED-CT	Sinus CT	-	10/2/2012

G) Vital Signs

Vitals	Date	Value
Height	10/2/2012	64 in
Weight	10/2/2012	124 lbs
Blood Pressure	10/2/2012	120/78 mmHg
BMI	10/2/2012	21.3

H) Laboratory Values/ Results

Test Code	Code System	Name	Actual Result	Date
30313-1	LOINC	HGB	12.4 g/dl	10/2/2012
33765-9	LOINC	WBC	19.1 (10^3/ul)	10/2/2012
26515-7	LOINC	PLT	255 (10^3/ul)	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

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

L) Encounter Diagnosis

Code	Code System	Description	Date	Finding	Finding Code
99222	CPT	Inpatient admission	Test date	Neoplasm of accessory sinus	126675008

M) Cognitive and Functional Status

Cognitive Condition	Code	Code System	Date	Status
Memory impairment	386807006	SNOMED-CT	10/5/2012	Active

Functional Condition	Code	Code System	Date	Status
Dependence on Walking Stick	105504002	SNOMED-CT	10/5/2012	Active

N) Discharge Instructions

You were admitted to Local Community Hospital on 10/2/2012 with a diagnosis of left maxillary sinus mass. You underwent a biopsy of the sinus mass and were treated with IV antibiotics. You tolerated the procedure without complications and your condition improved. You were discharged from Local Community Hospital on 10/5/2012 with instructions to follow up with Dr. Rodriguez. 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 heavy lifting, straining, or nose blowing
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. Intractable nausea or vomiting
    e. High fever
    f. Uncontrollable bleeding
    g. Pain or redness at the site of any previous intravenous catheter
    h. Any other unusual symptoms
4. Schedule a follow up appointment with your primary care physician in one week