Test Data for §170.314(e)(2) Ambulatory setting only – clinical summary

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.

Introduction

This document contains a sample of test data to be used as an illustration of 170.314.e.2. This section of the Code of Federal Regulations Title 45 documents the required EHR technology to be able to incorporate a summary care record formatted according to the Consolidated CDA.

A) Test of 45 CFR §170.314(e)(2) Ambulatory setting only – clinical summary
   (i) Create. Create. Enable a user to create a clinical summary for a patient in human readable format and formatted according to the standards adopted at § 170.205(a)(3).
   (ii) Customization. Enable a user to customize the data included in the clinical summary.

B) Summary of test data presented herein:
   To exemplify 170.314.e.2, the following clinical scenario will be employed. Ms. Isabella Jones is a 65-year-old white female with a history of moderate persistent asthma controlled on albuterol for breakthrough. She presented to Dr. Henry Seven at the Get Well Clinic on August 6th, 2012 with mild fevers, chills, and a cough productive of greenish sputum for the past 2 days. Ms. Jones was diagnosed by Dr. Seven with community acquired pneumonia with mild hypoxemia. She was treated and was referred to Dr. George Potomac for a pulmonology consultation. The data presented in this test scenario constitutes what should be contained in the Clinical Summary made available by Get Well Clinic's EHR to the patient.

Header Data

A) Patient Demographics

Name	Sex	Date of Birth	Race	Ethnicity	Preferred Language	Home Address
Isabella Jones	F	5/1/1947	White	Not Hispanic or Latino	English	1357 Amber Dr. Beaverton, OR 97867

B) Encounter Information

Provider Name	Provider Office Contact	Date of Visit	Visit Location	Care Team Members
Dr. Henry Seven Get Well Clinic 1002 Healthcare Dr. Portland, OR 99123	Mary McDonald Tel: 555-555-1002	8/6/2012	Get Well Clinic 1002 Healthcare Dr. Portland, OR 99123	Provider – Dr. Henry Seven Husband – Frank Jones

Body Data

A) Medication Allergies

Code	CodeSystem	Allergy Substance	Reaction	Severity	Status
7982	RxNorm	Penicillin G benzathine	Hives	Moderate to Severe	Inactive
2670	RxNorm	Codeine	Shortness of Breath	Moderate	Active
1191	RxNorm	Aspirin	Hives	Mild to Moderate	Active

B) Medications Administered During Visit

Code	CodeSystem	Medication	Start Date	Route	Dose/Frequency
573621	RxNorm	albuterol 0.09 MG/ ACTUAT metered dose	8/6/2012	Inhalation	0.09 MG/ACTUAT inhalant solution, 2 puffs once

C) Medications

Code	CodeSystem	Medication	Start Date	Route	Dose	Status	Fill Instructions
197517	RxNorm	clarithromycin	8/6/2012	Oral	500 mg tablet, twice daily for 7 days	Active	Generic substitution allowed
866924	RxNorm	metoprolol tartrate	5/1/2009	Oral	25 mg tablet, once daily	Active	Generic substitution allowed
573621	RxNorm	albuterol 0.09 MG/ACTUAT metered dose	1/3/2007	Inhalation	0.09 MG/ACTUAT inhalant solution, 2 puffs every 6 hours PRN wheezing	Active	Generic substitution allowed

D) Problems

Code	CodeSystem	Problem Name	Start Date	End Date	Status
233604007	SNOMED-CT	Pneumonia	8/6/2012		Active
195967001	SNOMED-CT	Asthma	1/3/2007	-	Active

E) Reason for Visit/ Chief Complaint

- Mild Fever, 2 days
- Chills, 2 days
- Cough productive of greenish sputum, 2 days

F) Assessment

a. Pneumonia

b. Asthma exacerbation

G) 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)	8/6/2012

H) Clinical Instructions/ Patient Decision Aids

- Patient may continue to experience low grade fever and chills
- Return to clinic or call 911 if you experience chest pain, shortness of breath, high fevers, or intractable vomiting/diarrhea

I) Immunizations or Immunizations Administered during visit

Vaccine Code	CodeSystem	Vaccine Name	Date	Status
88	CVX	Influenza virus vaccine	11/1/2005	Completed
88	CVX	Influenza virus vaccine	9/10/2006	Completed
09	CVX	Tetanus- diphtheria adult	1/4/2007	Completed
33	CVX	Pneumococcal polysaccharide	8/6/2012	Completed

J) Vital Signs

Vitals	Date	Value
Height	11/1/2008	177 cm
Weight	11/1/2008	86 kg
Blood Pressure	11/1/2008	132/86 mmHg
BMI	11/1/2008	27.45

Vitals	Date	Value
Height	8/6/2012	177 cm
Weight	8/6/2012	88 kg
Blood Pressure	8/6/2012	145/88 mmHg
BMI	8/6/2012	28.09

K) Laboratory Values/ Results

Test Code	Code System	Name	Actual Result	Date
30313-1	LOINC	HGB	10.2 g/dl	8/6/2012
33765-9	LOINC	WBC	12.3 (10^3/ul)	8/6/2012
26515-7	LOINC	PLT	223 (10^3/ul)	8/6/2012

L) Care Plan (this section applies to those tests/procedures scheduled for the future or that have been done and need to be followed-up by the outpatient physician)

a. Diagnostic Tests Pending

Test Code	Code System	Name	Actual Result	Date
6460-0	LOINC	Sputum Culture	-	8/6/2012

b. Future Scheduled Tests

i. Scheduled Imaging

Code	CodeSystem	Procedure Name	Scheduled Date
168731009	SNOMED-CT	Chest X-Ray	8/13/2012

ii. Scheduled Lab Tests

Test Code	Code System	Name	Scheduled Date
30313-1	LOINC	HGB	8/13/2012

iii. Scheduled Procedures

Code	CodeSystem	Procedure Name	Schedule Date
45378	CPT	Colonoscopy	8/22/2012

M) Referrals to Other Providers

a. Dr. George Potomac, 222 Anymed Way, Portland, OR 99123 on 8/20/2012 for a pulmonology consultation

N) Future Appointments

a. Dr. Henry Seven, 1007 Healthcare Dr., Portland, OR 99123 on 8/14/2012 for follow up

O) Social History

Element Description	Description	Start Date	End Date	Code	Code System
Smoking Status	Current every day smoker (1 pack per day)	5/1/1992	2/27/2009	8517006	SNOMED-CT
Smoking Status	Former Smoker	2/27/2009	-	230056004	SNOMED-CT