

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

Reference the test procedure for test data implementation.

Ambulatory Setting

This section contains test data to be used as an illustration of 170.314(b)(2) in the ambulatory setting. The data contained within this document are intended to provide a patient record to be formatted according to the Consolidated CDA IG (HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation, DSTU Release 1.1 Draft Standard for Trial Use July 2012) and subsequently transmitted.

TD170.314(b)(2) – 1: Ambulatory

To exemplify 170.314(b)(2), the following clinical scenario will be employed.

Mr. Adam Everyman is a 50-year-old White male with a history of asthma controlled by albuterol for breakthrough. He presented at Get Well Clinic on August 15, 2012 with a one day history of increased difficulty breathing. Nancy Nightingale, RN, took Mr. Everyman's vital signs after which Dr. Samir Khan saw him. Dr. Khan diagnosed Mr. Everyman with costochondritis. He was instructed to take over-the-counter analgesic medication as needed and was referred to Dr. Penny Puffer, a pulmonologist, for pulmonary function tests.

A) Patient Demographics

- Patient name: Adam Everyman
- Sex: M
- Date of birth: 10/22/1962
- Race: White
- Ethnicity: Not Hispanic or Latino
- Preferred language: English

B) Care Team

- Dr. Samir Khan, Tel, 555-555-1004, Get Well Clinic, 1004 Healthcare Dr. Portland, OR 97005
- Nancy Nightingale, RN, 555-555-1014, Get Well Clinic, 1004 Healthcare Dr. Portland, OR 97005

C) Social History

- Smoking Status: Never smoker, [SNOMED-CT: 266919005]

D) Medication Allergies

Allergen: Penicillin G benzathine, [RxNorm: 7982]

Reaction: Hives

Status: Vendor supplied (for example, Active)

Allergen: Codeine, [RxNorm: 2670]

Reaction: Nausea

Status: Vendor supplied (for example, Active)

- E) Medications
 - Albuterol 0.09 MG/ACTUAT [Proventil], [RxNorm: 573621], 2 puffs every 6 hours PRN wheezing, **select any date prior to 8/15/2012**, Active
- F) Problems
 - Costochondritis, [SNOMED CT: 64109004], Start: 8/15/2012, Active
 - Asthma, [SNOMED-CT: 195967001], 9/25/2011, Active
- G) Procedures
 - None
- H) Vital Signs
 - Height: 70 in.
 - Weight: 195 lbs
 - Blood Pressure: **Select systolic** (140-160)/**Select diastolic** (90-100) mmHg
 - BMI: 28
- I) Laboratory Tests and Values/Results
 - CO₂, [LOINC: 2028-9], **Select** (23-29) mmol/L, 8/15/2012
- J) Immunizations
 - Influenza virus vaccine, [CVX: 88], 8/15/2012, Completed
- K) Care Plan (Goals and Instructions)
 - Goal: weight loss, [SNOMED CT: 289169006],
 - Instructions: diet and exercise counseling provided during visit

 - Goal: asthma management, [SNOMED CT: 406162001]
 - Instructions: resources and instructions provided during visit
- L) Encounter Diagnosis
 - Costochondritis, [SNOMED-CT: 203523006], Start: 8/15/2012, Active
- M) Functional and Cognitive Status
 - No impairment, [SNOMED-CT: 66557003], 8/15/2012, Active
- N) Referral
 - Pulmonary function tests, Dr. Penny Puffer, Tel: 555-555-1049, 1047 Healthcare Drive, Portland, OR 97005, Scheduled date: Test date + 2 days

Inpatient Setting

This section contains test data to be used as an illustration of 170.314(b)(2) in the inpatient setting. The data contained within this section are intended to provide a patient record formatted according to the Consolidated CDA IG (HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation, DSTU Release 1.1 Draft Standard for Trial Use July 2012).

TD170.314(b)(2) – 2: Inpatient

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 three hour history of increasingly severe chest pain radiating into left arm and lower jaw, which began immediately after vigorous exercise. Mr. Williams underwent an EKG administered by Nancy Nightingale, RN, which demonstrated no abnormalities. He was admitted by Dr. Alan Admit, placed on oxygen therapy and underwent serial troponins. He was subsequently discharged on hospital day #2 with a diagnosis of angina and instructions to follow up with his primary care physician.

A) Patient Demographics

- Patient name: John Williams
- Sex: M
- Date of birth: 4/7/1947
- Race: Black
- Ethnicity: Not Hispanic or Latino
- Preferred language: English

B) Care Team

- Nancy Nightingale, RN, 555-555-1014, Local Community Hospital, 4444 Hospital Way, Portland, OR 97005
- Dr. Aaron Admit, 555-555-1006, 1006 Healthcare Drive, Portland OR 97005

C) Social History

- Smoking Status: Never smoker, [SNOMED-CT: 266919005]

D) Medication Allergies

Allergen: Penicillin G benzathine, [RxNorm: 7982]

Reaction: Hives

Status: Vendor supplied (for example, Active)

Allergen: Codeine, [RxNorm: 2670]

Reaction: Nausea

Status: Vendor supplied (for example, Active)

E) Medications

- Insulin, Aspart, Human [NovoLog], [RxNorm: 284810], **Select value** (15, 20, 25) units, three times daily before meals, Sub-cutaneous, Start: 1/9/2009, Active

- Lantus, [RxNorm: 261551], 1/9/2009, Sub-cutaneous, **Select value** (30, 40, 50) units, once daily before sleep, Active
- Atorvastatin 40 MG Oral Tablet [Lipitor], [RxNorm: 617320], 8/8/2008, once daily, Active
- Aspirin 81 MG Oral Tablet, [RxNorm: 243670], once daily, Start: 10/2/2012, Active

F) Problems

- Angina, [SNOMED CT: 194828000], Start: 10/2/2012, Active
- Type II Diabetes, [SNOMED CT: 190424003], Start: 1/9/2009, Active
- Hypercholesterolemia, [SNOMED CT: 13644009], Start: 8/8/2008, Active

G) Procedures

- ECG, [SNOMED CT: 142008000] or [CPT: 93000], 10/2/2012
- Intranasal oxygen therapy, [SNOMED-CT: 71786000], 10/2/2012

H) Vital Signs

- Height: 178 cm
- Weight: 82 kg
- Blood Pressure: **Select systolic** (140-160)/**Select diastolic** (90-100) mmHg
- BMI: 25.9

I) Laboratory Tests and Values/ Results

- Na, [LOINC: 2947-0], **Select value** (135-145) mmol/L, 10/2/2012
- K, [LOINC: 6298-4], **Select value** (3.5-5.1) mmol/L, 10/2/2012
- Cl, [LOINC: 2069-3], **Select value** (95-110) mmol/L, 10/2/2012
- CO₂, [LOINC: 2028-9], **Select value** (23-29) mmol/L, 10/2/2012
- BUN, [LOINC: 6299-2], **Select value** (8-24) mg/dL, 10/2/2012
- Cr, [LOINC: 38483-4], **Select value** (0.8-1.3) mg/dL, 10/2/2012
- Glu, [LOINC: 2339-0], **Select value** (185-205) mg/dL, 10/2/2012
- Troponin T, [LOINC: 6598-7], 0.01 ng/ml, 10/2/2012
- Troponin T, [LOINC: 6598-7], 0.01 ng/ml, 10/3/2012

J) Immunizations

- Influenza virus vaccine, [CVX: 88], 10/2/2012, Completed

K) Care Plan (Goals and Instructions)

- Goal: stress management surveillance, [SNOMED-CT: 410418004]
- Instructions: counseling provided during visit

L) Encounter Diagnosis

- Angina, [SNOMED CT: 194828000], Start: 10/2/2012, Active

M) Cognitive and Functional Status

- Memory impairment, [SNOMED-CT: 386807006], 10/2/2012, Active
- Dependence on walking stick, [SNOMED-CT: 105504002], 10/2/2012, Active

N) 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.

Notes

- Where permitted by the Consolidated CDA IG (HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation, DSTU Release 1.1 Draft Standard for Trial Use July 2012), and not otherwise restricted by a code system or the 2014 Edition Certification Criteria (Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology, Final Rule) alternate code systems to those presented here may be used.
- Where permitted by the Consolidated CDA IG, and not otherwise restricted by a code system or the 2014 Edition Certification Criteria, coded examples maybe replaced with text-only entries.
- Blood pressure may be recorded as separate systolic and diastolic values.
- Where permitted by the Consolidate CDA IG, and not otherwise restricted by a code system, metric units of measure may be used.
- Status and dates are vendor supplied unless provided below; dates are to include month, day and year, no standard date format is required.
- Vendors may supply alternate vocabulary codes, provided they are valid, appropriate and meet the 2014 Edition Certification Criteria requirements.

Document History

Version Number	Description of Change	Date Published
1.0	Released for public comment	October 17, 2012
1.1	Delivered for National Coordinator Review	December 3, 2012
1.2	Posted Approved Test Data	December 14, 2012