

Test Data for §170.314(b)(1) Transitions of care – receive, display, and incorporate transition of care/referral summaries

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.1 - Ambulatory

This document contains a sample of test data to be used as an illustration of 170.314(b)(1) in the ambulatory setting. The data contained within this document is intended to populate the medication list, problem list, and medication allergy list, along with basic patient demographics. This data will supplement the data contained within the C-CDA formatted document that the EHR will receive, display, and incorporate. The Vendor may supply additional data to optionally populate other portions of the patient record, at the discretion of the Vendor.

To exemplify 170.314(b)(1), the following clinical scenario will be employed. Ms. Myra 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 6, 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 document constitutes what should be entered into the patient's EHR record, prior to receiving a C-CDA formatted document.

A) Patient Demographics

Name	Sex	Date of Birth	Race	Ethnicity	Preferred Language
Myra Jones	F	5/1/1947	White	Not Hispanic or Latino	English

B) Medication Allergies

Code	CodeSystem	Allergy Substance	Reaction	Severity	Status
208416	RxNorm	Bactrim	Rash	Select (Moderate, Severe)	Active
1191	RxNorm	Aspirin	Hives	Select (Mild, Moderate)	Active

C) Medications

Code	CodeSystem	Medication	Start Date	Route	Dose	Status	Fill Instructions
1165655	RxNorm	fluticasone inhaled	10/1/2007	Inhalant/Respiratory	Select (88, 110, 220, 440) mcg twice daily	Active	Generic substitution allowed
866924	RxNorm	metoprolol tartrate	5/1/2009	Oral	Select (50, 100, 150, 200) mg twice daily	Active	Generic substitution allowed

D) Problems

Code	CodeSystem	Problem Name	Start Date	End Date	Status
38341003	SNOMED-CT	Hypertension	5/1/2009	-	Active
195967001	SNOMED-CT	Asthma	1/3/2007	-	Active

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TD170.314.b.1 – Inpatient

This document contains a sample of test data to be used as an illustration of 170.314(b)(1). The data contained within this document is intended to populate the medication list, problem list, and medication allergy list, along with basic patient demographics in the inpatient setting. This data will supplement the data contained within the C-CDA formatted document that the EHR will receive, display, and incorporate. The Vendor may supply data to optionally populate other portions of the patient record, at the discretion of the Vendor.

To exemplify 170.314 (b) (1), 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 Proventil for breakthrough. She presented to Dr. Henry Seven at the Get Well Clinic on August 6, 2012 with acute onset shortness of breath with fevers, chills, and cough productive of greenish sputum for the past 2 days. Ms. Jones was directly admitted to the hospital by Dr. Seven with a diagnosis of community acquired pneumonia with mild hypoxemia. The data presented in this document constitutes what should be entered into the patient's EHR record, prior to receiving a C-CDA formatted document.

A) Patient Demographics

Name	Sex	Date of Birth	Race	Ethnicity	Preferred Language
Isabella Jones	F	5/1/1947	White	Not Hispanic or Latino	English

B) Medication Allergies

Code	CodeSystem	Allergy Substance	Reaction	Severity	Status
208416	RxNorm	Bactrim	Rash	Select (Moderate, Severe)	Active
1191	RxNorm	Aspirin	Hives	Select (Mild, Moderate)	Active

C) Medications

Code	CodeSystem	Medication	Start Date	Route	Dose	Status	Fill Instructions
1154602	RxNorm	albuterol inhaled	8/6/2012	Inhalant/Respiratory	2.5mg/3ml NEB select (3, 4) times daily PRN wheezing/shortness of breath	Active	Generic substitution allowed
1152108	RxNorm	ceftriaxone	8/6/2012	IV	Select (1, 2) gram IV once daily	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

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