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

Reference the Test Scenario Procedure for Test Scenario Data implementation guidance.

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.

Ms. Myra Jones is a 66-year-old White female with a history of pneumonia, hypertension and asthma controlled by albuterol for breakthrough. Following her discharge from Community Health and Hospitals on August 13, 2012, she presented at Get Well Clinic on August 16, 2012 with a three day history of increased difficulty breathing. Nancy Nightingale, RN, took Ms. Jones's vital signs after which Dr. Henry Seven saw her. Dr. Seven diagnosed Ms. Jones with pneumonia. She was instructed to use albuterol for breakthrough as needed, had labs performed, was given a prescription for ciprofloxacin and orders for a chest x-ray and CT scan, and was referred to Dr. George Potomac, a pulmonologist, for pulmonary function tests.

A) Patient Demographics

- Patient name: Myra Jones
- Sex: F
- Date of birth: 05/01/1947
- Race: White
- Ethnicity: Not Hispanic or Latino
- Preferred language: English

B) Care Team

- Dr. Henry Seven, 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: Former smoker, [SNOMED-CT: 8517006]

D) Medication Allergies

Allergen: Bactrim, [RxNorm: 208416]
Reaction: Rash
Status: Vendor supplied (for example, Active)

Allergen: Codeine, [RxNorm: 2670]
Reaction: Shortness of breath
Status: Vendor supplied (for example, Active)

Allergen: Aspirin, [RxNorm: 1191]
Reaction: Hives
Status: Vendor supplied (for example, Active)

E) Medications

- Fluticasone 110 mcg, [RxNorm: 1165655], one puff inhale twice daily, 8/1/2012, Active
- Metoprolol Tartrate 25 mg, [RxNorm: 866924], one tablet by mouth twice daily, 2/10/2010, Active
- Ciprofloxacin 500 mg, [RxNorm: 309309], one tablet by mouth every 12 hours for three days, 8/16/2012, Active
- Albuterol 0.09 MG/ACTUAT [Proventil], [RxNorm: 573621], 2 puffs every 6 hours PRN wheezing, 8/16/2012, Active

F) Problems

- Hypertension, [SNOMED CT: 38341003], Start: 5/1/2009, Active
- Pneumonia, [SNOMED CT: 233604007], Start: 8/6/2009, Active
- Asthma, [SNOMED-CT: 195967001], 1/3/2007, Active

G) Procedures

- None

H) Vital Signs

- Height: 69 in.
- Weight: 194 lbs
- Blood Pressure: 130/82 mmHg
- BMI: 28.6

I) Laboratory Tests and Values/Results

- HGB, [LOINC 30313-1], 14.2 g/dl, 8/16/2012
- HCT, [LOINC 4544-3], 45%, 8/16/2012
- WBC, [LOINC 6690-2], 7.6 (10^3/ul), 8/16/2012
- PLT, [LOINC 777-3], 220 (10A^3/ul), 8/16/2012

J) Immunizations

- Influenza virus vaccine, [CVX: 88], 5/6/2012, Completed
- Pneumococcal polysaccharide, [CVX: 33], 8/6/2012, Completed
- Tetanus and diphtheria toxoids, [CVX : 113], 4/14/2012, Completed

K) Care Plan (Goals and Instructions)

- Goal: asthma management, [SNOMED CT: 406162001]
  Instructions: resources and instructions provided during visit

L) Encounter Diagnosis

- Pneumonia, [SNOMED-CT: 233604007], 8/6/2009, Active

M) Functional and Cognitive Status

- Memory impairment, [SNOMED-CT: 386807006], 10/2/2008, Active
- Dependence on walking stick, [SNOMED-CT: 105504002}, 10/2/2008, Active

N) Referral

- Pulmonary function tests, Dr. George Potomac , Tel: 555-555-1049, 1047 Healthcare Drive, Portland, OR 97005, Scheduled date: 8/20/2012

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:

Ms. Isabella Jones is a 66-year-old White female with a history of pneumonia and asthma controlled by albuterol for breakthrough. She presented to Get Well Clinic with a one day history of difficulty breathing, and was recommended for inpatient admission for pneumonia. She presented to the emergency department at Local Community Hospital on August 6, 2012. Nancy Nightingale, RN, took Ms. Jones's vital signs and she was admitted by Dr. Alan Admit and underwent a chest x-ray and CT scan. She was subsequently discharged on hospital day #3 with a diagnosis of pneumonia and asthma, and given instructions to follow up with her primary care physician.

A) Patient Demographics

- Patient name: Isabella Jones
- Sex: F
- Date of birth: 5/1/1947
- Race: White
- 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: Former smoker, [SNOMED-CT: 8517006]

D) Medication Allergies

Allergen: Bactrim, [RxNorm: 208416]
Reaction: Rash
Status: Vendor supplied (for example, Active)

Allergen: Codeine, [RxNorm: 2670]
Reaction: Shortness of breath
Status: Vendor supplied (for example, Active)

Allergen: Aspirin, [RxNorm: 1191]
Reaction: Hives
Status: Vendor supplied (for example, Active)

E) Medications

- Albuterol 2.5 mg / 3 mL, [RxNorm: 1154602], nebulizer by mouth four times daily as needed, 8/6/2012, Active
- Ceftriaxone 1 gram, [RxNorm: 1152108], intravenously once daily, 8/6/2012, Active
- Albuterol 0.09 MG/ACTUAT [Proventil], [RxNorm: 573621], 2 puffs every 6 hours PRN wheezing, 5/27/2012, Active

F) Problems

- Pneumonia, [SNOMED CT: 233604007], Start: 8/6/2012, Active
- Asthma, [SNOMED-CT: 195967001], 1/3/2007, Active

G) Procedures

- Chest X-Ray, PA and Lateral Views, [SNOMED CT: 168731009] or [CPT: 71020], 8/9/2012
- CT thorax w/o contrast material [CPT: 71250], 8/9/2012

H) Vital Signs

- Height: 175 cm
- Weight: 88 kg
- Blood Pressure: 145/88 mmHg
- BMI: 28.6

I) Laboratory Tests and Values/ Results

- HGB, [LOINC 30313-1], 12.4 g/dl, 8/9/2012
- HCT, [LOINC 4544-3], 45%, 8/9/2012
- WBC, [LOINC 6690-2], 19.1 (10^3/ul), 8/9/2012
- PLT, [LOINC 777-3], 255 (10^3/ul), 8/9/2012

J) Immunizations

- Influenza virus vaccine, [CVX: 88], 5/4/2012, Completed
- Tetanus and diphtheria toxoids, [CVX : 113], 4/14/2012, Completed

K) Care Plan (Goals and Instructions)

- Goal: asthma management, [SNOMED CT: 406162001]
  Instructions: resources and instructions provided during visit

L) Encounter Diagnosis

- Pneumonia, [SNOMED CT: 233604007], Start: 8/6/2012, Active
- Asthma, [SNOMED-CT: 195967001], 1/3/2007, Active

M) Cognitive and Functional Status

- Memory impairment, [SNOMED-CT: 386807006], 10/2/2008, Active
- Dependence on walking stick, [SNOMED-CT: 105504002}, 10/2/2008, Active

N) Discharge Instructions

You were admitted to Local Community Hospital on 8/6/2012 with a diagnosis of pneumonia. You underwent a chest x-ray and CT scan and had hemoglobin, hematocrit, leukocytes, and platelets drawn. All tests were normal. You were treated with IV antibiotics and your condition improved. You were discharged from Local Community Hospital on 8/9/2012 with instructions to follow up with Dr. Seven. 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:
   - Chest pain
   - Shortness of breath
   - Dizziness or light-headedness
   - Intractable nausea or vomiting
   - High fever
   - Uncontrollable bleeding
   - Pain or redness at the site of any previous intravenous catheter
   - 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 may be replaced with text-only entries.
- Blood pressure may be recorded as separate systolic and diastolic values.
- Where permitted by the Consolidated 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; dates are to include month, day and year, no standard date format is required unless specified by the Consolidated CDA IG.
- 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
1.0	Posted for Feedback	September 11, 2013