Description
The patient`s vital signs gradually return to normal. At 2 PM, the patient`s laboratory and radiology tests results are provided to the attending physician. The tests indicate that the infant has influenza, and does not have pneumonia. The patient`s mother is provided with treatment information and prescriptions for her infant son. The working diagnoses (ICD-9 CM 487.1 and 380.53) are resolved/inactivated, and at 5 PM the patient is discharged home with final diagnoses of influenza and stenosis of external ear canal due to inflammation. Big City Children's Urgent Care is an outpatient facility operated by Children's Hospital of Big City that routinely sends electronic syndromic surveillance data to the Big City Health Department (BCHD) in accordance with a city regulation. At 6:00 PM on February 20, 2010, the facility`s electronic health record module for syndromic surveillance data assembles and transmits a Discharge ADT message about this patient encounter to BCHD.

Comments
This Test Scenario provides an example of clinical encounter that could take place in either an urgent care or emergency clinical setting. It is therefore applicable to EHR technology used in some ambulatory settings. Dates and times are provided in this test scenario to illustrate the sequence of clinical and messaging events. Since the exact dates and times are not reproducible when modeling the test scenario with EHR technology, only date and time format will be validated within tester submitted test data.

Pre-condition
A04-Registration message is sent before A03-Discharge message.

Post-Condition
No PostCondition

Test Objectives
This test step examines a Health IT Module's ability to create ADT^A03 Discharge message within PHIN Messaging Guide's conformance requirements.

Evaluation Criteria
Message Validation Report

Notes
Per ONC, for certification testing HIT developers must demonstrate that their system supports either the ICD-10 CM or SNOMED CT value set and are no longer required to demonstrate support for the ICD-9 CM value set (this policy is not conformant to the PHIN Syndromic Surveillance Messaging Guide, Rel2.0, April 2015). ICD-9 CM codes still are provided in the test data for coding the final diagnoses. The HIT developer must supply equivalent ICD-10 CM or SNOMED CT code data in the test message. If the HIT developer uses ICD-10 CM or SNOMED CT codes that are equivalent to the ICD-9 CM codes provided, the Tester may ignore errors generated by the Test Tool related to incorrect code/name of coding system and must determine via

visual inspection whether the ICD-10 CM or SNOMED CT code data are valid.

ICD-10 CM diagnosis codes are acceptable with or without decimals.

Although the other units of measure for patient age are acceptable in general (and the Context-free validation accepts any of the valid units of measure for age), this Scenario specifies that "mo" for months be used in this message for the Context-based validation.

Visit Number ID (PV1-19.1) must be populated with the same value for all messages included in this Test Case to reflect the requirement in real-world installations. Test Tool does not automatically test for this requirement, so Testers must manually inspect the messages to verify that PV1-19.1 is the same for all Test Step messages for a given Test Case.