Description

At 9:00 AM the next day, August 18, 2015, the patient is visited by the surgeon and an attending physician who perform a physical to check for signs and symptoms of any post-operation compilations. The patient reports that he is not experiencing any chest pain. The physicians both observe that the patient has signs of cardiac arrhythmia (I49.9), but conclude that he is otherwise in good condition. They clear the patient for discharge. At 12:00 PM the patient goes home.

Mountainview General Hospital reports inpatient syndromic surveillance data to the state health department (SHD) for all new patient discharges once per day. At 1:00 AM on August 19, 2015, the hospital's electronic health record module for syndromic surveillance data assembles and transmits an ADT^A03 Discharge message about this encounter to SHD.

Comments

This Test Case provides an example of an inpatient visit where syndromic surveillance data are sent to a public health agency in accordance with guidelines recommended by the International Society for Disease Surveillance. The dates and times in this test case illustrate the sequence of clinical and messaging events. Since the exact dates and times are not reproducible when modeling the test case with EHR technology, only date and time format will be validated within tester submitted test data.

Pre-condition

A01-Admission 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-10 CM codes are provided in the test data for coding the admit/encounter reason and final diagnosis. If the HIT developer uses different but equivalent ICD-10 CM codes than the ones provided or equivalent SNOMED CT codes, the Tester may ignore errors generated by the Test Tool related to incorrect code/name of coding system when the ICD-10 CM or SNOMED CT code data used in the message are determined via visual inspection to be valid data.

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

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.