2015 S&CC Test Data for 170.315 (g) (9) - API Access to Documents

In-Patient Setting

I. INTRODUCTION

This document contains sample test data that can be used for the certification towards 2015 objective 170.315(g)(9). This section of the Code of Federal Regulations Title 45 documents the required Health IT technology to be able to create a summary care record formatted according to the Consolidated CDA (C-CDA) Release 2.1

A) Test of 45 CFR 170.315 (g) (9)

<Include text of 45 CFR 170.315 (g) (9) here for reference>

B) Summary of test data presented herein

To exemplify 170.315 (g) (9), the following clinical scenario will be employed.

Document Narrative:

Ms. Jeremy Bates is a 35 year old male who is healthy and visits Community Health Hospitals on 7/22/2015 6pm EST due to a skin burn. The doctor examines the burn, applies the needed dressing and discharges the person after a few hours.

II. HEADER DATA

The following data is part of the medical record header identifying the contextual information necessary when exchanging data.

A) Patient Demographics

CCDS Data Elements	Contextual Data Elements required for the Medical Record encoding to C-CDA IG	Details	Additional Information
Patient Name		First Name: Jeremy	
		Last Name: Bates	
		Middle Name:	
		Previous Name:	
		Suffix:	
Sex		Male (M)	
Date of Birth		8/1/1980	
Race		Unknown	
More Granular		Unknown	
Race Code			

CCDS Data Elements	Contextual Data Elements required for the Medical Record encoding to C-CDA IG	Details	Additional Information
Ethnicity		Unknown	
Preferred		English (eng)	
Language			
	Home Address	1357, Amber Dr,	
		Beaverton, OR-97006	
	Telephone Number	Mobile: 555-777-1234	
		Home: 555-723-1544	

B) Relevant Information regarding the Visit

The information in this table is provided for context and to help populate the required elements in the C-CDA Header along with any 2015 S&CC data elements.

CCDS Data	Contextual Data	Details	Additional
Elements	Elements required		Information
	for medical record encoding to C-CDA		
Providers Name	chedding to C-CDA	Dr Henry Seven	Dr Seven and his staff
		First Name: Henry	work for Community
		Last Name: Seven	Health and Hospitals
			1002, Healthcare Dr,
			Portland, OR-97266
Office Contact		Mary McDonald	
Information		First Name: Mary	
		Last Name: McDonald	
		Telephone: 555-555-1002	
	Author/Legal	Dr Henry Seven	
	Authenticator/Authe		
	nticator of Electronic	Time: 7/22/2015	
	Medical Record		
	System that	Neighborhood Physicians	
	generated the	Practice EMR	
	document		
	Informants	Kathy Bates (Spouse)	
		First Name: Kathy	
		Last Name: Bates	
	Medical Record	Community Health and	
	Custodian	Hospitals	
	Information	Dr Henry Seven	
	Recipient	_ /2.2 /2.2 / 2.2 / 2.2	
	Admission Date	7/22/2015 6pm EST	

CCDS Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	Discharge Date Care Team Members	7/22/2015 11pm EST Dr Henry Seven Mary McDonald	
	Other Participants in event	Mr Mathew Bates (Grand Parent) First Name: Mathew Last Name: Bates Ms Kathy Bates (Spouse) First Name: Kathy Last Name: Bates.	
	Event Documentation Details or Documentation of Event	Dr Henry Seven (PCP) 5 hour encounter Event Code = Burn by Fire	Code for Burn by Fire: 423123007, Code System: SNOMED-CT

III. BODY DATA

The following data is part of the medical record details identifying the relevant clinical data captured as part of the visit.

- A) Medication Allergies:
 - a. No known Food Allergy (SNOMED-CT code =429625007)
 - b. No known environmental allergy (SNOMED-CT code = 428607008)
 - c. No known history of drug allergy (SNOMED-CT code = 409137002)
- B) Medications Administered during stay (These medications were administered during the stay at the hospital)
 - a. None.
- C) Problems:
 - a. No known health problems
- D) Encounter Diagnoses

Code	CodeSystem	Description	Start Date	Service
				Delivery
				Location

Code	CodeSystem	Description	Start Date	Service Delivery Location
<u>T23.1</u>	ICD-10	Burn of first degree of wrist and hand	7/22/2015	Community Health and Hospitals 1002, Healthcare Dr, Portland, OR-97266

E) Procedures

Code	CodeSystem	Procedure Name	Target Site	Start Date	End Date	Performer
90660004	SNOMED- CT	Application of Dressing for burn	281737009 (Skin of part of forearm) – SNOMED CT code	7/22/2015	7/22/2015	Community Health and Hospitals 1002, Healthcare Dr, Portland, OR-97266

- F) Immunizations or Immunizations Administered during visit
 - a. No Immunization history
- G) Vital Signs

Code	Code System	Vitals	Date	Value
8302-2	LOINC	Height	7/22/2015	177 cm
			6:10 pm EST	
3141-9	LOINC	Weight	7/22/2015	88 kg
			6:10 pm EST	
8462-4	LOINC	Blood Pressure	7/22/2015	145/88 mmHg
(Diastolic)			6:15 pm EST	
8480-6 (Systolic)				
8310-5	LOINC	Body	7/22/2015	99 degree
		Temperature	6:20 pm EST	Farenheit

- H) Laboratory Test: None needed.
- I) Laboratory Values/Results: No Lab Result data

J) Smoking Status and Tobacco Use

Element	Description	Start Date	End Date	Code	Code System
Description					
Current	Current	7/22/2015	-	449868002	SNOMED-CT
Smoking Status	every day	6:30 pm			
		EST			

- K) UDI List: No implanted devices.
- L) Assessment and Plan of Treatment:
 - a. **Assessment (Visual Inspection** ATL's need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content)
 - The patient Mr Jeremy Bates was found to have first degree burns and Dr Seven and his staff Mr Bates by cleaning the burn and dressing the burn and observed for couple of hours before discharging Mr Bates.
 - b. **Plan of Treatment (Visual Inspection** ATL's need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content)
 - Schedule an appointment with Dr Seven after 1 week for Follow up with Outpatient facility.
 - ii. In case of high fever, take Tylenol as needed.
- M) Goals: No goal information.
- N) HealthConcerns: No Health concerns Information
- O) Discharge Instructions (**Visual Inspection** ATL's need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content)
 - a. Appointments: Schedule an appointment with Dr Seven after 1 week. Follow up with Outpatient facility.
 - b. In case of fever, take Tylenol as advised in plan of treatment.
- P) Functional Status: No information
- Q) Cognitive Status: No information