2015 S&CC Test Data for 170.315 (b) (1) Transitions of Care

In-patient setting

I. INTRODUCTION

This document contains sample test data that can be used for the certification towards 2015 objective 170.315(b)(1). This section of the Code of Federal Regulations Title 45 documents the required Health IT technology to be able to create, send and receive a summary care record formatted according to the Consolidated CDA (C-CDA) Release 2.1 and be able to receive a summary care record formatted according to the C-CDA Release 1.1.

A) Test of 45 CFR 170.315 (b) (1)

<Include text of 45 CFR 170.315 (b) (1) here for reference>

B) Summary of test data presented herein

To exemplify 170.315 (b) (1), the following clinical scenario will be employed.

Document Narrative:

Ms. Alice Newman is a 45 year old female with a history of Hypertension, Hypothyroidism, Iron deficiency and is a recipient of Renal Allograft is admitted on 6/22/2015 at 10 am EST to Community Health and Hospitals with history of intermittent fever for 2 days. The patient disclosed history of nausea, loose stools and weakness. She was found to have Anemia secondary to iron deficiency and CKD. After conducting multiple tests and administering necessary medications, the patient was discharged to Ambulatory facility to follow up with immunosuppression as an out-patient. The condition of the patient at discharge was stable, with controlled blood sugar levels and a pain score below 3. Additional follow up instructions have been provided to the patient.

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

CCDS Data Elements	Contextual Data Elements required for the Medical Record encoding to C-CDA IG	Details	Additional Information
Patient Name		First Name: Alice Last Name: Newman Middle Name: Jones Previous Name: Alicia Suffix: jr	
Sex		Female (F)	
Date of Birth		5/1/1970	
Race		White (2106-3)	
More Granular Race Code		2108-9(White European)	
Ethnicity		Not Hispanic or Latino (2186-5)	
Preferred Language		English (eng)	
	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 Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
Providers Name		Dr Henry Seven First Name: Henry Last Name: Seven	Dr Seven and his staff work for Community Health and Hospitals 1002, Healthcare Dr, Portland, OR-97266
Office Contact Information		Mary McDonald First Name: Mary Last Name: McDonald Telephone: 555-555-1002	
	Author/Legal Authenticator/Authenticator of Electronic Medical Record	Dr Henry Seven Time: 6/22/2015	

CCDS Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	System that generated the document	Community Health Hospitals EMR	
	Informants	Frank Jones (Spouse) First Name: Frank Last Name: Jones	
	Medical Record Custodian	Community Health and Hospitals	
	Information Recipient	Dr Henry Seven	
	Admission Date	6/22/2015	
	Discharge Date	6/24/2015	
	Care Team Members	Dr Henry Seven Mary McDonald	
	Other Participants in event	Mr Ralph Issac (Grand Parent) First Name: Ralph Last Name: Issac Mr Frank Jones(Spouse) – Same Address information as Ms Isabella Jones.	
	Event Documentation Details or Documentation of Event	Dr Henry Seven (PCP) 2 day encounter Event Code = Anemia	Code for Anemia Finding: **164139008** , 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

Code	CodeSystem	Allergy Substance	Reaction	Severity	Date/Time	Concern Status	Notes
7982	RxNorm	Penicillin G benzathine	Hives (code-247472004, SNOMED-CT)	Moderate	Start – 5/10/1980 End – Not applicable	Active	

Code	CodeSystem	Allergy Substance	Reaction	Severity	Date/Time	Concern Status	Notes
81953	RxNorm	Ampicillin Sodium	Hives (code-247472004, SNOMED-CT)	Moderate	Start – 5/10/1980 End - Unknown	Active	
81982	RxNorm	Clindamycin Hydrochloride				Completed	No Allergies to Clindamycin Hydrochloride

B) Medications Administered during stay (These medications were administered during the stay at the hospital), End Dates for Medications is the same as the Encounter End Date.

Code	CodeSystem	Medication	Start Date	Route	Frequency	Dose
563973	RxNorm	Ceftriaxone 250MG/ML	6/22/2015	Injectable	BID	250MG/ML
47835	RxNorm	Vantin (cefpodoxime 100mg)	6/22/2015	Oral	BID	100mg
209459	RxNorm	Tylenol 500mg	6/22/2015	Oral	As needed	500 mg
576586	RxNorm	Darbepoetin Alfa 0.5 MG/ML	6/22/2015	Injectable	Once a week	0.5 MG/ML
748747	RxNorm	Clindamycin 300mg	6/23/2015	Oral	TID	300 mg
568809	RxNorm	Torsemide 20mg	6/23/2015	Oral	Qd	20 mg
40144	RxNorm	Levothyroxine Sodium	6/23/2015	Oral	QD	-
668657	RxNorm	Prednisolone 10mg	6/23/2015	Oral	QD	10mg
860887	RxNorm	FenoFibric Acid 35 mg	6/24/2015	Oral	QHS	35mg

Code	CodeSystem	Medication	Start Date	Route	Frequency	Dose
541585	RxNorm	Mycophenolic Acid 360 mg	6/24/2015	Oral	BID	360 mg
977435	RxNorm	Everolimus 0.5 mg	6/24/2015	Oral	BID	0.5 mg
848958	RxNorm	Ciprofloxacin 2mg/ml	6/25/2015	Oral	TID	2mg/ml

C) Medications to continue after the encounter. (These medications are to be continued after the stay).

Code	CodeSystem	Medication	Timing Information	Route	Frequency	Dose
209459	RxNorm	Tylenol 500mg	6/24/2015, No End Date	Oral	As needed	500 mg
668657	RxNorm	Prednisolone 10mg	StartDate: 6/24/2015 End Date: 7/4/2015	Oral	QD	10mg
860887	RxNorm	FenoFibric Acid 35 mg	StartDate: 6/24/2015 End Date: 7/4/2015	Oral	QHS	35mg
541585	RxNorm	Mycophenolic Acid 360 mg	StartDate: 6/24/2015 End Date: 6/27/2015	Oral	BID	360 mg
977435	RxNorm	Everolimus 0.5 mg	StartDate: 6/24/2015 End Date: 7/20/2015	Oral	BID	0.5 mg
848958	RxNorm	Ciprofloxacin 2mg/ml	StartDate: 6/24/2015 End Date: 7/24/2015	Oral	TID	2mg/ml

D) Problems

Code	CodeSystem	Problem Name	Timing Information	Health concern status	Notes
59621000	SNOMED-CT	Essential hypertension (Disorder,)	10/5/2015	Active	
83986005	SNOMED-CT	Severe Hypothyroidism (Disorder)	31/12/2006	Active	
236578006	SNOMED-CT	Chronic rejection of renal transplant (disorder)	31/12/2011	Active	
87522002	SNOMED-CT	Iron deficiency anemia (disorder)	6/22/2015	Active	
64667001	SNOMED-CT	Interstitial pneumonia (disorder)	6/22/2015	Active	
238131007	SNOMED-CT	Overweight (finding)	31/12/2006 – Start Date 6/1/2007 – End Date	Completed	
44054006	SNOMED-CT	Diabetes Mellitus Type 2 (Disorder)		Completed	No history of diabetes mellitus type 2.

E) Encounter Diagnoses

Code	CodeSystem	Description	Start Date	Service Delivery Location
D63.1	ICD-10	Anemia in Chronic Kidney Disease	6/22/2015	Community Health and Hospitals 1002, Healthcare Dr, Portland, OR-97266

F) Procedures

Code	CodeSystem	Procedure Name	Target Site	Start Date	End Date	Performer
10847001	SNOMED-CT	Bronchoscopy	91724006 (Tracheobronchial structure (body structure)	6/22/2015	6/22/2015	Community Health and Hospitals 1002, Healthcare Dr, Portland, OR-97266
168731009	SNOMED-CT	Chest X-Ray, PA and Lateral Views	82094008 (Lower Respiratory Tract Structure)	6/22/2015	6/22/2015	Community Health and Hospitals 1002, Healthcare Dr, Portland, OR-97266
175135009	SNOMED-CT	Introduction of cardiac pacemaker system via vein	9454009 – Structure of subclavian vein, Code System - SNOMED-CT	10/5/2011	10/5/2011	Community Health and Hospitals 1002, Healthcare Dr, Portland, OR-97266

G) Immunizations or Immunizations Administered during visit

Vaccine Code	CodeSystem	Vaccine Name	Date	Status	Lot Number	Manufacturer Name	Additional Notes
88	CVX	Influenza Virus Vaccine	5/10/2014	Completed	1	Immuno Inc.	
103	CVX	Tetanus and diphtheria toxoids	1/4/2012	Completed	2	Immuno Inc.	
166	CVX	influenza, intradermal, quadrivalent, preservative free	6/22/2015	Cancelled	1	Immuno Inc.	Immunization was not given - Patient rejected immunization

H) Vital Signs

Code	Code System	Vitals	Date	Value
8302-2	LOINC	Height	6/22/2015	177 cm
3141-9	LOINC	Weight	6/22/2015	88 kg
8462-4 (Diastolic) 8480-6 (Systolic)	LOINC	Blood Pressure	6/22/2015	145/88 mmHg

I) Laboratory Test

Test Code	Code System	Name	Date
24357-6	LOINC	Urinanalysis macro (dipstick) panel	6/22/2015
58410-2	LOINC	CBC	6/22/2015

J) Laboratory Values/Results

Test Code	Code System	Name	Actual Result	Date	Reference Range
30313-1	LOINC	HGB	10.2 g/dl	6/22/2015	
33765-9	LOINC	WBC	12.3 (10+3/ul)	6/22/2015	N/A - 500,000
26515-7	LOINC	PLT	123 (10+3/ul)	6/22/2015	
50544-6	LOINC	Everolimus Blood	10 ng/ml	6/22/2015	3.0-8.0 ng/ml
5778-6	LOINC	Color of Urine	YELLOW	6/22/2015	YELLOW
5767-9	LOINC	Appearance of Urine	CLEAR	6/22/2015	CLEAR
5811-5	LOINC	Specific gravity of Urine by Test strip	1.015	6/22/2015	1.005 – 1.030
5803-2	LOINC	pH of Urine by Test strip	5.0 pH	6/22/2015	5.0-8.0
5792-7	LOINC	Glucose [Mass/volume] in urine by test strip	50mg/dl	6/22/2015	Neg
5797-6	LOINC	Ketones [Mass/Volume] in urine by test strip	Negative	6/22/2015	Negative
5804-0	LOINC	Protein[Mass/Volume] in urine by test strip	100mg/dl	6/22/2015	negative

K) Smoking Status and Tobacco Use

Element Description	Description	Start Date	End Date	Code	Code System
Smoking Status	Heavy tobacco smoker	5/1/2005	2/27/2011	428071000124103	SNOMED-CT
Smoking Status	Current every day smoker	2/27/2011	-	449868002	SNOMED-CT
Current Smoking Status	Current every day	6/22/2015 11:30am	-	449868002	SNOMED-CT

L) UDI List

UDI	Assigning Authority	Device Code	Scoping Entity
00643169007222	FDA	704708004 - Cardiac resynchronization therapy implantable pacemaker, CodeSystem – SNOMED-CT	FDA

M) Assessment and Plan of Treatment:

a. **Assessment (Visual Inspection)**

i. The patient was found to have Anemia and Dr Seven and his staff diagnosed the condition and treated Ms Alice for Anemia during the 2 day stay at Community Health Hospitals. Ms Alice recovered from Anemia during the stay and is being discharged in a stable condition. If there is fever greater than 101.5 F or onset of chest pain/breathlessness the patient is advised to contact emergency.

b. **Plan of Treatment (Visual Inspection)**

i. Schedule an appointment with Dr Seven after 1 week for Follow up with Outpatient facility for Immunosuppressive therapy.

N) Goals: **(Visual Inspection)**

a. Need to gain more energy to do regular activities.(**Visual Inspection)**

b. Negotiated Goal to keep Body Temperature at 98-99 degrees Fahrenheit with regular monitoring.

O) HealthConcerns: **(Visual Inspection)**

a. Chronic Sickness exhibited by patient

b. HealthCare Concerns refer to underlying clinical facts

i. Documented HyperTension problem

ii. Documented HypoThyroidism problem

iii. Watch Weight of patient

iv. Documented Anemia problem

P) Discharge Instructions **(Visual Inspection)**

a. Diet: Diabetic low salt diet
b. Medications: Take prescribed medications as advised.
c. Appointments: Schedule an appointment with Dr Seven after 1 week. Follow up with Outpatient facility for Immunosuppression treatment.
d. For Fever of > 101.5 F, or onset of chest pain/breathlessness contact Emergency.

Q) Functional Status

Functional Condition	Code	Code System	Start Date
Dependence on Cane	105504002	SNOMED-CT	5/1/2005
Memory Impairment	386807006	SNOMED-CT	2/27/2011

R) Cognitive Status

Cognitive Status	Code	Code System	Start Date
Amnesia	48167000	SNOMED-CT	5/1/2005