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:

Mr. John Wright 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.

Note: The test data provided in the document was captured during this encounter including historical data. The contextual data provided is to help the vendors create their C-CDA documents using appropriate data. Vendors can ignore the contextual data if it is not required for C-CDA generation; however the generated C-CDA is expected to contain the data relevant to the criteria as specified in the regulation.

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: John Last Name: Wright Middle Initial: R Previous Name: Suffix: jr	
Sex		Male (M)	
Date of Birth		8/1/1980	
Race		Unknown	
More Granular Race Code		Unknown	
Ethnicity		Unknown	
Preferred Language		English (en)	
	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: 7/22/2015	

CCDS Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	System that generated the document	Community Health and Hospitals Practice EMR	
	Informants	Kathy Wright (Spouse) First Name: Kathy Last Name: Wright	
	Medical Record Custodian	Community Health and Hospitals	
	Information Recipient	Dr Henry Seven	
	Admission Date	7/22/2015 6pm EST	
	Discharge Date	7/22/2015 11pm EST	
Care Team Members	Care Team Members	Dr Henry Seven Mary McDonald	
	Other Participants in event	Mr Mathew Wright (Grand Parent) First Name: Mathew Last Name: Wright Ms Kathy Wright (Spouse) First Name: Kathy Last Name: Wright. (Same address information as Mr John Wright for both Mathew and Kathy).	
	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 Allergies

B) Medications
   a. No known Medications.

C) Problems:

a. No known problems

D) Encounter Diagnoses

Code	CodeSystem	Description	Start Date	Service Delivery Location
T23.1	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

Note: Target Site is provided for context, vendors may or may not choose to include this as part of the C-CDA entries.

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

a. No Immunization history

G) Vital Signs

Code	Code System	Vitals	Date	Value
8302-2	LOINC	Height	7/22/2015 6:10 pm EST	177 cm
3141-9	LOINC	Weight	7/22/2015 6:10 pm EST	88 kg

Code	Code System	Vitals	Date	Value
8462-4 (Diastolic) 8480-6 (Systolic)	LOINC	Blood Pressure	7/22/2015 6:15 pm EST	145/88 mmHg
8310-5	LOINC	Body Temperature	7/22/2015 6:20 pm EST	99 degree Farenheit

H) Laboratory Test: No Lab Tests.

I) Laboratory Values/Results: No Lab Result data

J) Smoking Status and Tobacco Use

Note: The C-CDA IG specifies how Smoking Status has to be represented using a combination of Tobacco Use and Smoking Status templates. Vendors are expected to follow the C-CDA IG to encode these data elements appropriately

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

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**)**
   i. The patient Mr John Wright was found to have first degree burns and Dr Seven and his staff Mr Wright by cleaning the burn and dressing the burn and observed for couple of hours before discharging Mr Wright.

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**)**
   i. 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 information.

N) HealthConcerns: No 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