

2015 S&CC Test Data for 170.315 (b) (4) – CCDS Create

In-Patient Setting

**I. INTRODUCTION**

This document contains sample test data that can be used for the certification towards 2015 objective 170.315(b)(4). 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 (b) (4)

<Include text of 45 CFR 170.315 (b) (4) here for reference>

B) Summary of test data presented herein

To exemplify 170.315 (b) (4), 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 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 Race Code		Unknown	

Ethnicity		Unknown	
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

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	
	Data Enterer during visit	Mary McDonald	
	Informants	Kathy Bates (Spouse) First Name: Kathy Last Name: Bates	
	Electronic Medical Record Custodian	Community Health and Hospitals	
	Information Recipient	Dr Henry Seven	
	Admission Date	7/22/2015 6pm EST	
	Discharge Date	6/24/2015 11pm EST	
	Care Team Members	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:

- No known Food Allergy (SNOMED-CT code =429625007)
- No known environmental allergy (SNOMED-CT code = 428607008)
- 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)

- None.

#### C) Problems:

- No known health problems

#### D) Encounter Diagnoses

Code	CodeSystem	Description	Start Date	Service Delivery Location
<a href="#">T23.1</a>	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
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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
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F) Immunizations or Immunizations Administered during visit

a. No Immunization history

G) 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
8310-5	LOINC	Body Temperature	7/22/2015	99 degree Fahrenheit

H) Laboratory Test: None needed.

I) Laboratory Values/Results: No Lab Result data

J) Smoking Status

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

K) UDI List: No implanted devices.

L) Assessment and Plan of Treatment:

a. **Assessment (Visual Inspection)**

- i. 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**

- i. Schedule an appointment with Dr Seven after 1 week for Follow up with Outpatient facility.
- ii. In case of high fever, take Tylenol according to the following.

209459 - Code	<b>RxNorm</b>	<b>Tylenol 500mg</b>	<b>Oral - Route</b>	<b>As needed</b>	<b>1 unit - Dose</b>
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iii.

**M) Goals**

- a. No goal information.

**N) HealthConcerns**

- a. No Health concerns

**O) Discharge Instructions**

- 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) CEHRT's are expected to represent data elements which are part of the CCDS with no information in this document using HL7 best practices for no information.**