2017 eHealth Exchange Content Testing Test Data - CREATE

I. INTRODUCTION

This document contains sample test data that SHALL be used for the eHealth Exchange Testing Program for Product Vendors. Participants will have the option to leverage this test data or provide a fully populated C-CDA document with their own test data.

Conventions used in the document:

1. The test data outlined below has both required and optional data that is specified to help the vendors create C-CDA's with the appropriate context and follow the HL7 C-CDA best practices. The optional data is indicated by enclosing them in [ ]. For e.g. [Medical Record Custodian] or [Allergy Substance].
    a. When a narrative or text block is surrounded by [ ] the entire narrative block is optional.
    b. When a column heading is surrounded by [ ] the data represented by the column is optional. For e.g. [Allergy Substance], the display name is optional.
    c. When the data within a table cell is surrounded by [ ] the data within the cell is optional. For e.g. The information recipient Dr Albert Davis is optional from a certification standpoint. Vendors can include it in their C-CDA's to comply with HL7 C-CDA IG and best practices.

[Information Recipient]	[Dr Albert Davis]

2. Additional clarifications are added with the keyword "**Note**".
3. Data that needs to be visually inspected by the eHealth Exchange testing staff in the generated C-CDA's are indicated by the key word "**Visual Inspection".**
4. Guidance for No Information Sections: When the test data instructions specify "No Information" for certain data elements, vendors are expected to use the HL7 recommended best practices to represent the information. However vendors don't have to include sections and entries not required by the document template to represent "No information".

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 visits Neighborhood Physicians Practice on 6/22/2015 at 10am EST. The patient disclosed history of nausea, loose stools and weakness. After initial examination the patient was found to have fever, she was administered necessary medications and after examining the history of the patient and the lab results, the doctor suspected anemia. So the patient was referred to Community Health Hospitals an Inpatient facility to get appropriate treatment and was asked to watch for appropriate changes in body temperature, blood pressure and take nebulizer treatment as needed.]

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.

II. HEADER DATA

Note: 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: Alice Last Name: Newman Middle Name: Jones Previous Name: Alicia Suffix:	The Previous Name specified is the Patient's Birth Name and should be coded accordingly.
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 Languag		English (en)	
	Home Address	1357, Amber Dr, Beaverton, OR-	

CCDS Data Elements	Contextual Data Elements required for the Medical Record encoding to C-CDA IG	Details	Additional Information
	Telephone Number	Mobile: 555-777-1234 Home: 555-723-1544	

B) Relevant Information regarding the Visit

Note: The information in this table is provided for context and to help populate the required elements in the C-CDA Header along with any Meaningful Use Common Clinical Data Set data elements.

CCDS Data Elements	Contextual Data Elements required for medical record encoding to C-	Details	Additional Information
Referring or Transitioning Providers Name		Full Name: Dr Albert Davis First Name: Albert Last Name: Davis	
Office Contact Information		Full Name: Tracy Davis First Name: Tracy Last Name: Davis Telephone: 555-555-1002 Address: 2472, Rocky place, Beaverton, OR- 97006	
	[Author/Legal Authenticator/Authenticator of Electronic Medical Record]	[Dr Albert Davis Date: 6/22/2015]	
	[System that generated the document]	[Neighborhood Physicians Practice EMR]	
	[Informants]	[Matthew Newman (Spouse) First Name: Matthew Last Name: Newman]	
	[Medical Record Custodian]	[Neighborhood Physicians Practice]	
	[Information Recipient]	[Dr Albert Davis]	
	[Visit Date]	[6/22/2015]	
Care Team	Care Team Members	Dr Albert Davis Tracy Davis	

CCDS Data Elements	Contextual Data Elements required for medical record encoding to C-	Details	Additional Information
	[Other Participants in event]	[Mr Rick Holler (Grand Parent) First Name: Rick Last Name: Holler Mr Matthew Newman (Spouse) First Name: Matthew Last Name: Newman (Mr Rick and Mr Matthew have the same address as Ms Alice)]	
	[Event Documentation Details or Documentation of Event]	[Dr Albert Davis 30 minute encounter Event Code = Fever]	[Code for Fever Finding: 386661006 , Code System: SNOMED-CT]

III. BODY DATA

Note: 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 Substanc	Reaction	Severity	Timing Information	Concern
7980 (IN)	RxNorm	Penicillin G	Hives (code-247472004, SNOME	Moderate	Start Date – 5/10/1980,	Active
733 (IN)	RxNorm	Ampicillin	Hives (code-247472004, SNOME	Moderate	Start Date – 5/10/1980,	Active

B) Medications

Code	CodeSystem	[Medication	Timing Informatio	Route	Frequency	Dose

Code	CodeSystem	[Medication	Timing Informatio	Route	Frequency	Dose
309090 (SCD)	RxNorm	Ceftriaxone 100 MG/ML	6/22/2015 – Start Date 6/30/2015 – End Date	Injectable	Two times daily	1 unit
209459 (SBD)	RxNorm	Tylenol 500mg	For 10 days, starting from	Oral	As needed	1 unit
731184 (SCD)	RxNorm	Darbepoetin Alfa 0.5 MG/ML	6/22/2015 – Start Date (No End Date)	Injectable	Once a week	1 unit

C) Problems

Code	CodeSystem	[Problem Name]	Timing Information	Concern Status
59621000	SNOMED-CT	Essential hypertension (Disorder	10/5/2011 – Start Date	Active
83986005	SNOMED-CT	Severe Hypothyroidism (Disorder)	12/31/2006 – Start Date	Active
236578006	SNOMED-CT	Chronic rejection of renal transplant	12/31/2011 – Start Date	Active
386661006	SNOMED-CT	Fever (finding)	6/22/2015 – Start Date	Active
238131007	SNOMED-CT	Overweight (finding)	12/31/2006 – Start Date, 6/1/2007 – End Date	Completed

D) Encounter Diagnoses

Code	CodeSystem	[Description]	Date Recorded	[Service Delivery Location

Code	CodeSystem	[Description]	Date Recorded	[Service Delivery Location
386661006	SNOMED-CT	Fever – Finding	6/22/2015	Neighborhood Physicians Practice Address: 2472, Rocky place, Beaverton, OR-97006

E) Immunizations

Note: Additional Notes represent why the Immunization was cancelled and there are no specific notes applicable to the completed immunizations.

Vaccine Code	CodeSystem	[Vaccine	Date	Status	[Lot Number	[Manufacturer Name]	Additional Notes
88	CVX	Influenza Virus Vaccine	5/10/2014	Completed	1	Immuno Inc.	N/A
106	CVX	Tetanus and diphtheria toxoids	1/4/2012	Completed	2	Immuno Inc.	N/A
166	CVX	influenza, intradermal, quadrivalent, preservative free	6/22/2015	Cancelled	No Lot number provided – Vendors need to use NullFlavor	Immuno Inc.	Immunization was not given - Patient rejected immunization

F) Vital Signs

Code	Code System	[Vitals Name]	Timing Information	Value and Units
8302-2	LOINC	Height	6/22/2015, [10:05 EST]	Value=177 units=cm
29463-7	LOINC	Weight	6/22/2015, [10:05 EST]	Value=88 units=kg
8462-4 (Diastolic) 8480-6	LOINC	Blood Pressure	6/22/2015, [10:08 EST]	Value=145/88 units=mm[Hg]
8867-4	LOINC	Heart Rate	6/22/2015 [10:10 EST]	Value=80 Units=/min

Code	Code System	[Vitals Name]	Timing Information	Value and Units
59408-5	LOINC	O2 % BldC Oximetry	6/22/2015 [10:12 EST]	Value=95 units=%
8310-5	LOINC	Body Temperature	6/22/2015 [10:15 EST]	Value=38 Units=Cel
9279-1	LOINC	Respiratory Rate	6/22/2015 [10:15 EST]	Value=18 units=/min

G) 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
Historical Smoking Status	Heavy tobacco smoker	5/1/2005	2/27/2011	428071000124103	SNOMED-CT
Current Smoking Status	Current every day	6/22/2015	-	449868002	SNOMED-CT

H) 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	[Procedure Name]	Date	[Target Site]	Status	[Service Delivery Location
(56251003) – SNOMED-CT	Nebulizer Therapy	6/22/2015	82094008-Lower Respiratory Tract Structure, Code System – SNOMED-CT	Completed	Neighborhood Physicians Practice Telephone: 555-555-1002 Address: 2472, Rocky place, Beaverton, OR-97006

Code	[Procedure Name]	Date	[Target Site]	Status	[Service Delivery Location
175135009 (SNOMED- CT)	Introduction of cardiac pacemaker system via vein	10/5/2011	9454009 – Structure of subclavian vein, Code System - SNOMED - CT	Completed	Community Health Hospitals. Telephone: 555-555-1003 Address: 3525, Newberry Avenue, Beaverton OR-

I) Laboratory Tests

Note: The pending Urinanalysis lab test has no results yet and is a future event and has to be coded accordingly. The HL7 best practice to code a pending lab test is to represent it with a planned observation in the Plan of Treatment section.

Test Code	Code System	[Name]	Date
24357-6	LOINC	Urinanalysis macro (dipstick) panel	6/22/2015
24357-6	LOINC	Urinanalysis macro (dipstick) panel	6/29/2015

J) Laboratory Values/Results

Note: The results below correspond to the Urinanlysis lab test on 6/22/2015. Reference Ranges such as YELLOW are optional and vendors may or may not choose to include them as part of their C-CDA entries. Additionally when units are not present then the result value does not require any specific unit.

Result Code	Code System	[Name]	Result Value and Units	Date	[Reference
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 –
5803-2	LOINC	pH of Urine by Test strip	Value=5.0 units=[pH]	6/22/2015	5.0-8.0
5792-7	LOINC	Glucose [Mass/volume] in urine by test strip	Value=50 units=mg/dL	6/22/2015	Neg
5797-6	LOINC	Ketones [Mass/Volume] in urine by test strip	Negative	6/22/2015	Negative

Result Code	Code System	[Name]	Result Value and Units	Date	[Reference
5804-0	LOINC	Protein[Mass/Volume] in urine by test	Value=100 units=mg/dL	6/22/2015	Negative

K) UDI:

Note: Device Code is provided for context, vendors may or may not choose to include this as part of the C-CDA entries. Also the implantable device identified below was introduced as part of the procedure documented in the procedure section namely "Introduction of cardiac pacemaker system via vein".

UDI	Assigning	[Device Code]	[Scoping Entity
(01)00643169007222(17)160128(21)BLC200461H	FDA	704708004 - Cardiac resynchronization therapy implantable pacemaker,	FDA

L) Assessment and Plan of Treatment:

a. **Assessment (Visual Inspection** – eHealth Exchange Testing staff need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content**)**
   i. The patient was found to have fever and Dr Davis is suspecting Anemia based on the patient history. So Dr Davis asked the patient to closely monitor the temperature and blood pressure and get admitted to Community Health Hospitals if the fever does not subside within a day.

b. **Plan of Treatment (Visual Inspection**– eHealth Exchange testing staff need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content**)**
   i. Get an EKG done on 6/23/2015.
   ii. Get a Chest X-ray done on 6/23/2015 showing the Lower Respiratory Tract Structure.
   iii. Take Clindamycin 300mg three times a day as needed if pain does not subside/
   iv. Schedule follow on visit with Neighborhood Physicians Practice on 7/1/2015.

M) Goals **(Visual Inspection** – eHealth Exchange testing staff need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content**)**
   a. Get rid of intermittent fever that is occurring every few weeks.
   b. Need to gain more energy to do regular activities

N) HealthConcerns **(Visual Inspection** – eHealth Exchange testing staff need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content**)**
   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

O) Reason For Referral: **(Visual Inspection** – eHealth Exchange testing staff need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content**)**

Ms Alice Newman is being referred to Community Health Hospitals Inpatient facility because of the high fever noticed and suspected Anemia.

P) Functional Status

[Functional Condition]	**Code**	**Code System**	**Date**
Dependence on Cane	105504002	SNOMED-CT	5/1/2005

Q) Cognitive Status

[Cognitive Status]	**Code**	**Code System**	**Date**
Amnesia	48167000	SNOMED-CT	5/1/2005