<u>(SVAP USCDI v2) Test Data for 170.315 (b) (1)- Transitions of Care</u>

<u>Ambulatory Setting</u>

I.   INTRODUCTION

This document contains sample test data that can be used for the certification towards 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)

The following is the summary of test data presented herein for 170.315(b)(1) criteria.

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 may not be represented in the C-CDA generated for certification. However, vendors may choose to include it in their C-CDA's to comply with HL7 C-CDA IG and best practices.

[Information Recipient]	[Dr Albert Davis]

    d. The C-CDA IG allows display names and text elements to be optionally included in the structured entries. Hence the above optional markings designated by [ ] in the test data are with respect to the structured entries in the XML. If a certification criteria requires visual display of the structured data (for e.g View, Download and Transmit - VDT), then the vendors have to display the coded data elements in their English representation. For example Medication Name, Problem Name, Vital Sign Name which are English representations of the coded data have to be displayed for the VDT criteria even though they are marked optional in the test data.
2. Additional clarifications are added with the keyword "**Note**".

3. Data that needs to be visually inspected by the ATL's in the generated C-CDA's are indicated by the key word "**Visual Inspection".**
4. <u>Guidance for No Information Sections:</u> 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".
5. <u>Guidance to Change Test Data:</u> Vendors can work with their ATLs to change the test data specified below. ATLs have been provided a document on how to use the test tools to verify SUT's capabilities when the test data is changed. This document has also been posted as part of ETT Google Group thread: https://groups.google.com/forum/#!topic/edge-test-tool/fDYr_kqp9_g

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

<u>Document Narrative:</u>

[Mr. Jeremy Bates is a 35 year old male who is healthy and visits Neighborhood Physicians Practice on 7/22/2015 2pm EST for a routine physical. The doctor conducts the physical and concludes that Jeremy is healthy and there are no current health concerns.]

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

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

A) USCDI Data Class/Element: Patient Demographics

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

USCDI Data Elements	Contextual Data Elements required for the Medical Record encoding to C-CDA IG	Details	Additional Information
Ethnicity		Unknown	
Preferred Language		English (en)	
Current Address	Home Address	1357, Amber Dr, Beaverton, OR-97006	
Phone Number		Mobile: 555-777-1234 Home: 555-723-1544	
Gender Identity		Identifies as Male Gender (SNOMED CT code 446151000124109)	
Sexual Orientation		Heterosexual state (SNOMED CT code 20430005)	

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 2015 S&CC data elements.

USCDI Data Class/Elements	Contextual Data Elements required for medical record encoding to C-CDA	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: 7/22/2015]	

USCDI Data Class/Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	[System that generated the document]	[Neighborhood Physicians Practice EMR]	
	[Informants]	[Kathy Bates (Spouse) First Name: Kathy Last Name: Bates]	
	[Electronic Medical Record Custodian]	[Neighborhood Physicians Practice]	
	[Information Recipient]	[Dr Albert Davis]	
	[Visit Date]	[7/22/2015]	
Care Team Members	Care Team Members	Dr Albert Davis (Primary Care Provider Function - 453231000124104) Tracy Davis (Professional nurse – 106292003) Telephone: 555-555-1002 Address: 2472, Rocky place, Beaverton, OR-97006	
	[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 (Mr Mathew and Ms Kathy have the same address Information as Mr Jeremy Bates)]	
	[Event Documentation Details or Documentation of Event]	[Dr Albert Davis 30 minute encounter Event Code = Caregiver Annual Health Check]	[Caregiver Annual Health Check: 699134002, 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) USCDI Data Class/Element: Allergies and Intolerances
   a. No known Allergies and Intolerances

Note: Allergies and Intolerances are to be represented using the Allergies and Intolerances Section.

B) USCDI Data Class/Element: Medications
   a. No known Medications.

C) USCDI Data Class/Element: Problems
   a. No known Problems

D) Encounter Diagnoses

Code	CodeSystem	[Description]	Start Date	Service Delivery Location
1025 13008	SNOMED-CT	Well Male Adult	7/22/2015	Neighborhood Physicians Practice Address: 2472, Rocky place, Beaverton, OR-97006

E) USCDI Data Class/Element: Immunizations
   a. No known immunization history

F) USCDI Data Class/Element: Vital Signs

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

G) USCDI Data Class/Element: Smoking Status

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

H) USCDI Data Class/Element: Procedures
   a. No Procedure information

I) USCDI Data Class/Element: Laboratory Tests
   a. No Lab Tests Information.

J) USCDI Data Class/Element: Laboratory Values/Results
   a. No Lab results Information.

K) USCDI Data Class/Element: Unique Device Identifiers for a Patient's Implantable Device(s)
   a. No implanted devices

L) USCDI Data Class/Element: 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 was found to be healthy and advised to follow his current routine of exercise, work, sleep and quality of life.
   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 a visit for next year.

M) Reason for Referral: No information

N) USCDI Data Class/Element: Goals
   a. No information

O) USCDI Data Class/Element: HealthConcerns
   a. No information.

P) Functional Status: No information

Q) Cognitive Status: No information

R) USCDI Data Class/Element: Clinical Notes **(Visual Inspection** – ATL's need to visually inspect the System Under Test (SUT) generated C-CDA for the text content**,** the validator will validate the presence of the notes section and entry. Only the text content needs to be visually inspected.)

R.1 History and Physical Note:

Dr Albert Davis examined Mr Jeremy Bates and found him to be healthy but advised him to cut down on smoking.