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

Ambulatory 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:

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.

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	

CCDS Data Elements	Contextual Data Elements required for the Medical Record encoding to C-CDA IG	Details	Additional Information
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

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
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 Time: 7/22/2015	
	System that generated the document	Neighborhood Physicians Practice EMR	
	Informants	Kathy Bates (Spouse) First Name: Kathy Last Name: Bates	

CCDS Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	Electronic Medical Record Custodian	Neighborhood Physicians Practice	
	Information Recipient	Dr Albert Davis	
	Visit Date	7/22/2015	
	Care Team Members	Dr Albert Davis Tracy Davis	
	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 Albert Davis 30 minute encounter Event Code = Annual Health Maintenance, History and Physical	Code for Annual Health Maintenance, History and Physical: 78318003, 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 Food Allergy (SNOMED-CT code =429625007)
   b. No known environmental allergy (SNOMED-CT code = 428607008)
   c. No known history of drug allergy (SNOMED-CT code = 409137002)

B) Medications: No known Medications.

C) Problems: No known Problems

D) Encounter Diagnoses

Code	CodeSystem	Description	Start Date	Service Delivery Location

Code	CodeSystem	Description	Start Date	Service Delivery Location
78318003	SNOMED-CT	Annual Health Maintenance, History and Physical	7/22/2015	Neighborhood Physicians Practice Address: 2472, Rocky place, Beaverton, OR-97006

E) Immunizations: No known immunization history

F) Vital Signs

Code	Code System	Vitals	Date	Value
8302-2	LOINC	Height	7/22/2015 2:05 pm EST	177 cm
3141-9	LOINC	Weight	7/22/2015 2:05 pm EST	88 kg
8462-4 (Diastolic) 8480-6 (Systolic)	LOINC	Blood Pressure	7/22/2015 2:10 pm EST	145/88 mmHg

G) Smoking Status and Tobacco Use

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

H) Procedures : No Procedure information

I) Laboratory Tests: No Lab Test required

J) Laboratory Values/Results: No Lab results

K) UDI: No implanted devices

L) Assessment and Plan of Treatment:

a. **Assessment and 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. The patient was found to be healthy and advised to follow his current routine of exercise, work, sleep and quality of life.
    ii. Schedule a visit for next year.

M) Goals: No information

N) HealthConcerns: No information.

O) Functional Status: No information

P) Cognitive Status: No information