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

In-Patient 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

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 ATL's 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".

To exemplify 170.315 (b) (1), 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

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: 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

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.

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 Date: 7/22/2015]	
	[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

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:
   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	[Service Delivery Location]

Code	CodeSystem	[Procedure Name]	[Target Site]	Start Date	End Date	[Service Delivery Location]
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 Name]	Date	Value and Units
8302-2	LOINC	Height	7/22/2015 [6:10 pm EST]	Value=177 Units=cm
29463-7	LOINC	Weight	7/22/2015 [6:10 pm EST]	Value=88 Units=kg
8462-4 (Diastolic) 8480-6 (Systolic)	LOINC	Blood Pressure	7/22/2015 [6:15 pm EST]	Value=145/88 units=mm[Hg]
8310-5	LOINC	Body Temperature	7/22/2015 [6:20 pm EST]	Value=99 Units=[degF]

H) Laboratory Test: No Lab Tests Information.

I) Laboratory Values/Results: No Lab Results Information.

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 treated 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