2015 S&CC Test Data for 170.315 (g) (9) – API Access to Documents

Ambulatory Setting

I. INTRODUCTION

This document contains sample test data that can be used for the certification towards 2015 objective 170.315(g)(9). 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 (g) (9)

<Include text of 45 CFR 170.315 (g) (9) 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 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]

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 (g) (9), 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.]

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: Jeremy Last Name: Bates Middle Initial: V 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
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]	
	[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 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 (Mr Mathew and Ms Kathy have the same address Information as Mr Jeremy Bates)]	

CCDS Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	[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) Medication Allergies:
   a. No known Allergies.

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

B) Medications: No known Medications.

C) Problems: No known Problems

D) Encounter Diagnoses

Code	CodeSystem	[Description]	Start Date	[Service Delivery Location]
699134002	SNOMED-CT	Caregiver Annual Health Check	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 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) 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

H) Procedures : No Procedure information

I) Laboratory Tests: No Lab Tests Information

J) Laboratory Values/Results: No Lab results Information

K) UDI: 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 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) Goals: No information

O) HealthConcerns: No information.

P) Functional Status: No information

Q) Cognitive Status: No information