Cures Update Test Data for 170.315 (g)(9) API Access
Ambulatory Setting

I. INTRODUCTION

This document contains sample test data that can be used for the certification towards Cures Update 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, 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 (g)(9)

The following is the summary of test data presented herein for 170.315(g)(9) 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 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]

    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. 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".
5. Guidance to Change Test Data: 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 (g)(9), the following clinical scenario will be employed.

Document Narrative:

[Ms. Happy Kid is a two year old girl with a Hypo Plastic Left Heart Syndrome visits Neighborhood Physicians Practice on 6/22/2020 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; 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

USCDI Data Elements	Contextual Data Elements required for the Medical Record encoding to C-CDA IG	Details	Additional Information
Patient Name		First Name: Happy Last Name: Kid Middle Name: Always Previous Name: N/A	
Sex		Female (F)	
Date of Birth		6/1/2019	
Race		White (2106-3)	

USCDI Data Elements	Contextual Data Elements required for the Medical Record encoding to C-CDA IG	Details	Additional Information
More Granular Race Code		2108-9(White European)	
Ethnicity		Not Hispanic or Latino (2186-5)	
Preferred Language		English (en)	
Current Address	Home Address	1357, Amber Dr, Beaverton, OR-97006	
Previous Address	Previous Home Address	1402 Dariy Dr, Beaverton, OR-97006	
Phone Number		Mobile: 555-777-1234 Home: 555-723-1544	
Email Address		happykid@gmail.com	

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 USCDI data elements.

USCDI 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	

USCDI Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	[Author/Legal Authenticator/Authenticator of Electronic Medical Record]	[Author Name, Dr Albert Davis Autor Timestamp: 6/22/2020, Author Organization: Neighborhood Physicians Practice]	
	[System that generated the document]	[Neighborhood Physicians Practice EMR]	
	[Informants]	[Matthew Newman (Father) First Name: Matthew Last Name: Newman]	
	[Medical Record Custodian]	[Neighborhood Physicians Practice]	
	[Information Recipient]	[Dr Albert Davis]	
	[Visit Date]	[6/22/2020]	
Care Team Members	Care Team Members	Dr Albert Davis, PCP, PCP Since: 6/1/2020	
	[Other Participants in event]	[Mr Rick Holler (Grand Parent) First Name: Rick Last Name: Holler Mr Matthew Newman (Father) First Name: Matthew Last Name: Newman (Mr Rick and Mr Matthew have the same address as Ms Happy)]	
	[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) Provenance Information

The following is the Provenance information that needs to be captured for each of the CCDA Entry templates that will be created using the test data provided in this document.

USCDI Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
[Author Name]		[Full Name: Dr Albert Davis] [First Name: Albert] [Last Name: Davis]	
Author Organization		Neighborhood Physicians Practice	
Author Timestamp		6/22/2020 11:00am ET	

B) Medication Allergies

Note: Medication Allergies are to be represented using the Allergies and Intolerances Section. The Start Date is to be represented using the effectiveTime data element of Allergy Intolerance Observation as biologically relevant time.

Code	CodeSystem	[Allergy Substance]	Reaction	Severity	[Timing Information]	Concern Status
1009148	RxNorm	Ampicillin	Hives (code-247472004, SNOMED-CT)	Moderate	Start Date – 12/1/2019	Active
372664007	SNOMED-CT	[Benzodiazepine]	Allergic Headache (code – 4448006, SNOMED-CT)	Mild	Start Date – 12/1/2019	Active

C) Medications

Note: Timing information (Start and End Dates) are to be represented using the effectiveTime data element in the Medication Activity entry.

Code	CodeSystem	[Medication Name]	[Timing Information]	Route	Frequency	Dose
309090 (SCD)	RxNorm	Ceftriaxone 100 MG/ML	6/22/2020 – Start Date 6/30/2020 – End Date	Injectable	Two times daily	1 unit
209459 (SBD)	RxNorm	Tylenol 500mg	For 10 days, starting from 6/22/2020	Oral	As needed	1 unit
731241 (SBD)	RxNorm	Aranesp 0.5 MG/ML	6/22/2020 – Start Date (No End Date)	Injectable	Once a week	1 unit

D) Problems

Note: Timing information is to be represented using the effectiveTime data element in the Problem Observation. Start Date is to be used as Onset Date and End Date as Resolution Date.

Code	CodeSystem	[Problem Name]	[Timing Information]	Concern Status
62067003	SNOMED-CT	Hypo Plastic Left Heart Syndrome	Start Date 6/1/2019	Active

E) Immunizations

No Information.

F) Vital Signs

Code	Code System	[Vitals Name]	Timing Information	Value and Units
8462-4 (Diastolic)	LOINC	Blood Pressure-Diastolic	6/22/2020, [10:08 EST]	Value=88 units=mm[Hg]
8480-6 (Systolic)	LOINC	Blood Pressure-Systolic	6/22/2020, [10:08 EST]	Value=145 units=mm[Hg]
8867-4	LOINC	Heart Rate	6/22/2020 [10:10 EST]	Value=80 Units=/min
59408-5	LOINC	O2 % BldC Oximetry	6/22/2020 [10:12 EST]	Value=95 units=%
3150-0	LOINC	Inhaled Oxygen Concentration	6/22/2020 [10:12 EST]	Value=36 units=%
8310-5	LOINC	Body Temperature	6/22/2020 [10:15 EST]	Value=38 units=Cel
9279-1	LOINC	Respiratory Rate	6/22/2020 [10:15 EST]	Value=18 units=/min
59576-9	LOINC	BMI Percentile	6/22/2020 [10:15 EST]	Value=60 units=percentile

Code	Code System	[Vitals Name]	Timing Information	Value and Units
77606-2	LOINC	Weight for Length Percentile	6/22/2020 [10:15 EST]	Value=42 Units=Percentile
8289-1	LOINC	Head Occipital-frontal Circumference Percentile	6/22/2020 [10:15 EST]	Value=25 Units=Percentile

G) Smoking Status and Tobacco Use

No Information on Smoking Status and Tobacco Use.

H) Procedures

No Information.

I) Laboratory Tests

No Information

J) Laboratory Values/Results

No Information

K) UDI:

No Information

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 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**– ATL's need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content**)**
      i. Get an EKG done on 6/23/2020.
      ii. Get a Chest X-ray done on 6/23/2020 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 7/1/2020.

M) Goals **(Visual Inspection** – ATL's 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** – ATL's 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

O) 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.)

O.1 Consultation Note:

Dr Albert Davis diagnosed Ms Happy Kid to be suffering from Fever and suspected Pneumonia and recommended admission to the Community Health Hospitals.