Cures Update (SVAP USCDI v3) 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 Cures Update 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. 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 (b) (1), the following clinical scenario will be employed.

Document Narrative:

[Mr. David Mahal is a 43 year old male who visits Community Health Hospitals on 7/22/2015 6pm EST due to breathlessness. At the hospital, the breathlessness increases severly and Mr Hollow looses his life.]

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: David Last Name: Mahal	
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
More Granular Race Code		Unknown	
Ethnicity		Unknown	
Preferred Language		English (en)	
Current Address	Home Address	1357, Death Dr, Beaverton, OR-97006	
Phone Number		Mobile: 555-777-6666 Home: 555-723-6666	
Death Date		7/22/2023	

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 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: 7/22/2023]	
	[System that generated the document]	[Community Health and Hospitals Practice EMR]	
	[Informants]	[Kathy Mahal (Spouse) First Name: Kathy Last Name: Mahal]	

USCDI Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	[Medical Record Custodian]	[Community Health and Hospitals]	
	[Information Recipient]	[Dr Henry Seven]	
	Admission Date	7/22/2023 6pm EST	
	Discharge Date	7/22/2023 11pm EST	
Care Team Members	Care Team Members	Dr Henry Seven Mary McDonald	
	[Other Participants in event]	Ms Kathy Mahal (Spouse) First Name: Kathy Last Name: Mahal. (Same address information as Mr David Mahal for Ms 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)   USCDI Data Class/Element: Allergies and Intolerances
  - a.   No Information

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

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

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

- D)   Encounter Diagnoses

Code	CodeSystem	[Description]	Start Date	Encounter Type	Service Delivery Location
R99	ICD-10	Dead (Unknown Cause)	7/22/2023	Inpatient Encounter Code - 99221	Community Health and Hospitals 1002, Healthcare Dr, Portland, OR-97266

E) USCDI Data Class/Element: Immunizations
   a. No Information

F) USCDI Data Class/Element: Vital Signs
   a. No Information

G) USCDI Data Class/Element: Smoking Status
   a. No Information

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 died during the encounter..

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