2015 S&CC Test Data for 170.315 (b) (9) – Care Plan

In-Patient Setting

I. INTRODUCTION

This document contains sample test data that can be used for the certification towards 2015 objective 170.315(b)(9). This section of the Code of Federal Regulations Title 45 documents the required Health IT technology to be able to create a Care Plan for a patient formatted according to the Consolidated CDA (C-CDA) Release 2.1

A) Test of 45 CFR 170.315 (b) (9)

<Include text of 45 CFR 170.315 (b) (9)here for reference>

B) Summary of test data presented herein

To exemplify 170.315 (b) (9), the following clinical scenario will be employed.

Document Narrative:

Ms. Alice Newman is a 45 year old female with a history of Hypertension, Hypothyroidism, Iron deficiency and is a recipient of Renal Allograft is admitted on 6/22/2015 at 10 am EST to Community Health and Hospitals with history of intermittent fever for 2 days. The patient disclosed history of nausea, loose stools and weakness. She was found to have Anemia secondary to iron deficiency and CKD. After conducting multiple tests and administering necessary medications, the patient was discharged to Ambulatory facility to follow up with immunosuppression as an out-patient. The condition of the patient at discharge was stable, with controlled blood sugar levels and a pain score below 3. Additional follow up instructions have been provided to the patient.

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

CCDS Data Elements	Contextual Data Elements required for the Medical Record encoding to C-CDA IG	Details	Additional Information
Patient Name		First Name: Alice Last Name: Newman Middle Name: Jones Previous Name: Alicia Suffix: jr	
Sex		Female (F)	
Date of Birth		5/1/1970	
Race		White (2106-3)	
More Granular Race Code		2108-9(White European)	
Ethnicity		Not Hispanic or Latino (2186-5)	
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
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 Time: 6/22/2015	

CCDS Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	System that generated the document	Community Health Hospitals EMR	
	Informants	Frank Jones (Spouse) First Name: Frank Last Name: Jones	
	Medical Record Custodian	Community Health and Hospitals	
	Information Recipient	Dr Henry Seven	
	Admission Date	6/22/2015	
	Discharge Date	6/24/2015	
	Care Team Members	Dr Henry Seven Mary McDonald	
	Other Participants in event	Mr Ralph Issac (Grand Parent) First Name: Ralph Last Name: Issac Mr Frank Jones(Spouse) – Same Address information as Ms Isabella Jones.	
	Event Documentation Details or Documentation of Event	Dr Henry Seven (PCP) 2 day encounter Event Code = Anemia	Code for Anemia Finding: **164139008** , 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) Medications Administered during stay (These medications were administered during the stay at the hospital), End Dates for Medications is the same as the Encounter End Date.

Code	CodeSystem	Medication	Start Date	Route	Frequency	Dose
309090	RxNorm	Ceftriaxone 100 MG/ML	6/22/2015	Injectable	BID	100 MG/ML

Code	CodeSystem	Medication	Start Date	Route	Frequency	Dose
47835	RxNorm	Vantin (cefpodoxime 100mg)	6/22/2015	Oral	BID	100mg
209459	RxNorm	Tylenol 500mg	6/22/2015	Oral	As needed	500 mg
576586	RxNorm	Darbepoetin Alfa 0.5 MG/ML	6/22/2015	Injectable	Once a week	0.5 MG/ML
748747	RxNorm	Clindamycin 300mg	6/23/2015	Oral	TID	300 mg
568809	RxNorm	Torsemide 20mg	6/23/2015	Oral	Qd	20 mg
40144	RxNorm	Levothyroxine Sodium	6/23/2015	Oral	QD	-
668657	RxNorm	Prednisolone 10mg	6/23/2015	Oral	QD	10mg
860887	RxNorm	FenoFibric Acid 35 mg	6/24/2015	Oral	QHS	35mg
541585	RxNorm	Mycophenolic Acid 360 mg	6/24/2015	Oral	BID	360 mg
977435	RxNorm	Everolimus 0.5 mg	6/24/2015	Oral	BID	0.5 mg
848958	RxNorm	Ciprofloxacin 2mg/ml	6/25/2015	Oral	TID	2mg/ml

B) Medications to continue after the encounter. (These medications are to be continued after the stay).

Code	CodeSystem	Medication	Timing Information	Route	Frequency	Dose
209459	RxNorm	Tylenol 500mg	6/24/2015, No End Date	Oral	As needed	500 mg
668657	RxNorm	Prednisolone 10mg	StartDate: 6/24/2015 End Date: 7/4/2015	Oral	QD	10mg
860887	RxNorm	FenoFibric Acid 35 mg	StartDate: 6/24/2015 End Date: 7/4/2015	Oral	QHS	35mg

C) Problems

Code	CodeSystem	Problem Name	Timing Information	Health concern status	Notes
59621000	SNOMED-CT	Essential hypertension (Disorder,)	10/5/2015	Active	
83986005	SNOMED-CT	Severe Hypothyroidism (Disorder)	31/12/2006	Active	
236578006	SNOMED-CT	Chronic rejection of renal transplant (disorder)	31/12/2011	Active	
87522002	SNOMED-CT	Iron deficiency anemia (disorder)	6/22/2015	Active	
64667001	SNOMED-CT	Interstitial pneumonia (disorder)	6/22/2015	Active	
238131007	SNOMED-CT	Overweight (finding)	31/12/2006 – Start Date	Active	

D) Encounter Diagnoses

Code	CodeSystem	Description	Start Date	Service Delivery Location

Code	CodeSystem	Description	Start Date	Service Delivery Location
D63.1	ICD-10	Anemia in Chronic Kidney Disease	6/22/2015	Community Health and Hospitals 1002, Healthcare Dr, Portland, OR-97266

E) Vital Signs

Code	Code System	Vitals	Date	Value
8302-2	LOINC	Height	6/22/2015	177 cm
3141-9	LOINC	Weight	6/22/2015	106 kg
8462-4 (Diastolic) 8480-6 (Systolic)	LOINC	Blood Pressure	6/22/2015	145/88 mmHg
8130-5	LOINC	Body Temperature	6/22/2015 10:07 am EST.	103 degree F
3141-9	LOINC	Weight	7/22/2015 10:05 EST	96 kg
8130-5	LOINC	Body Temperature	6/23/2015 10:07 am EST.	99 degree F
8130-5	LOINC	Body Temperature	6/24/2015 10:07 am EST.	98 degree F

F) Goals

a. Get rid of iron deficiency.
b. Need to gain more energy to do regular activities.
c. Negotiated Goal for Body Temperature (LOINC code - 8310-5, 98-99 degrees Fahrenheit, Date-6/22/2015, Related problem reference is as follows

Code	Code System	Description	Date	Status
87522002	SNOMED-CT	Iron deficiency anemia (disorder)	6/22/2015	Active

d. Keep weight under 95kg.

G) HealthConcerns

a. Health Status – 161901003, (Chronis Sickness) SNOMED-CT
b. HealthCare Concerns refer to underlying clinical facts
    i. HyperTension problem concern

ii. HypoThyroidism problem concern
iii. Vital Sign Weight Observation
iv. Iron deficiency Anemia Problem concern

H) Health Status Evaluations and Outcomes
   a. Outcome Observation #1:
      i. Refers to Goal Observation for Body Temperature
      ii. Refers to the Intervention Act #1
      iii. Progress Towards Goal of Body Temperature – Goal Achieved as of 7/22/2015
   b. Outcome Observation #2:
      i. Refers to Goal Observation for Weight
      ii. Refers to Intervention Act #2
      iii. Progress Towards Goal of Weight – Goal Not Achieved as of 7/22/2015

I) Interventions
   a. InterventionAct #1:
      i. Refers to the Medications entries
      ii. Refers to the Goal Observation for Body Temperature.
   b. InterventionAct #2:
      i. Nutrition Recommendations:
         1. Follow dietary regime as discussed , 182922004 – Dietary Regime (SNOMED-CT)
         2. Read about nutrition as discussed, 61310001 – Nutrition Education procedure, (SNOMED-CT)
      ii. Refers to the Goal Observation for Weight.

J) Discharge Instructions **(Visual Inspection** – ATL's need to visually inspect the System Under Test (SUT) generated C-CDA for the below narrative content**)**
   a. Diet: Follow Nutrition recommendations.
   b. Medications: Take prescribed medications as advised.
   c. Appointments: Schedule an appointment with Dr Seven after 1 week. Follow up with Outpatient facility for Immunosuppression treatment.
   d. For Fever of > 101.5 F, or onset of chest pain/breathlessness contact Emergency.
   e. Come in once a month to get a checkup of your weight and iron deficiency.