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

Ambulatory 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

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]
    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. [Service Delivery Location]
    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. 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".
4. 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) (9), the following clinical scenario will be employed.

Document Narrative:

[Ms. Karen Mckiney is a 45 year old female with a history of Hypertension, Hypothyroidism, Iron deficiency and is a recipient of Renal Allograft visits Neighborhood Physicians Practice on 6/22/2015 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

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: Karen Last Name: Mckiney Middle Name: Jones Previous Name: Cathy Suffix:	The Previous Name specified is the Patient's Birth Name and should be coded accordingly.
Sex		Female (F)	
Date of Birth		5/1/1970	
Race		White (2106-3)	

CCDS 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)	
	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 Time: 6/22/2015]	
	[System that generated the document]	[Neighborhood Physicians Practice EMR]	
	[Informants]	[Matthew Mckiney (Spouse) First Name: Matthew	

CCDS Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
		Last Name: Mckiney]	
	[Medical Record Custodian]	[Neighborhood Physicians Practice]	
	[Information Recipient]	[Dr Albert Davis]	
	[Visit Date]	[6/22/2015]	
Care Team Members	Care Team Members	Dr Albert Davis Tracy Davis	
	[Other Participants in event]	[Mr Rick Grazino (Grand Parent) First Name: Rick Last Name: Grazino Mr Matthew Mckiney (Spouse) First Name: Matthew Last Name: Mckiney (Mr Rick and Mr Matthew have the same address as Ms Karen)]	
	[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) 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
59621000	SNOMED-CT	Essential hypertension (Disorder,)	10/5/2011 – Start Date	Active
83986005	SNOMED-CT	Severe Hypothyroidism (Disorder)	12/31/2006 – Start Date	Active

Code	CodeSystem	[Problem Name]	Timing Information	Concern Status
236578006	SNOMED-CT	Chronic rejection of renal transplant (disorder)	12/31/2011 – Start Date	Active
386661006	SNOMED-CT	Fever (finding)	6/22/2015 – Start Date	Active
238131007	SNOMED-CT	Overweight (finding)	12/31/2006 – Start Date	Active

B) Encounter Diagnoses

Note: If a SUT only supports ICD-10 instead of SNOMED-CT, they could work with their ATLs to use a ICD-10 code.

Code	CodeSystem	[Description]	Start Date	[Service Delivery Location]
386661006	SNOMED-CT	Fever – Finding	6/22/2015	Neighborhood Physicians Practice Address: 2472, Rocky place, Beaverton, OR-97006

C) Vital Signs

Code	Code System	[Vitals Name]	Date	Value and Units
8302-2	LOINC	Height	6/22/2015, [10:05am EST]	Value=177 Units=cm
29463-7	LOINC	Weight	6/22/2015, [10:05 EST]	Value=110 Units=kg
8462-4 (Diastolic)	LOINC	Blood Pressure-Diastolic	6/22/2015, [10:08 EST]	Value=88 units=mm[Hg]
8480-6 (Systolic)	LOINC	Blood Pressure-Systolic	6/22/2015, [10:08 EST]	Value=145 units=mm[Hg]
8130-5	LOINC	Body Temperature	6/22/2015, [10:07 am EST].	Value=103 Units=[degF]

D) 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	6/22/2015 – Start Date End Date – 7/22/2015	Injectable	Two Times daily	1 unit
209459 (SBD)	RxNorm	Tylenol 500mg	6/22/2015 - Start Date, For 10 days	Oral	As needed	1 unit
731241 (SBD)	RxNorm	Aranesp 0.5 MG/ML	6/22/2015 – Start Date End Date – 7/22/2015	Injectable	Once a week	1 unit

E) Goals

a. Get rid of intermittent fever that is occurring every few weeks.
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
386661006	SNOMED-CT	**Fever (finding)**	6/22/2015	Active

d. Keep weight under 95kg.

F) HealthConcerns

a. Health Status – 161901003, (Chronic 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. Intermittent Fever Problem concern

G) Health Status Evaluations and Outcomes

a. Outcome Observation #1:
    i. Refers to Goal Observation for Weight
    ii. Refers to the Intervention Act #1
    iii. Progress Towards Goal of Weight – Goal Not Achieved as of 6/22/2015
b. Outcome Observation #2:
    i. Refers to Goal Observation for Body Temperature
    ii. Refers to Intervention Act #2

H) Interventions

a. InterventionAct #1:
    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.

b. InterventionAct #2:
   i. Refers to the Medications entries
   ii. Refers to the Goal Observation for Body Temperature.