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

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 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.

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: Alice Last Name: Newman Middle Name: Jones Previous Name: Alicia Suffix:	
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 (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

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	Dr Albert Davis	

CCDS Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	Authenticator/Authenticator of Electronic Medical Record	Time: 6/22/2015	
	Data Enterer during visit	Tracy Davis	
	Informants	Matthew Newman (Spouse) First Name: Matthew Last Name: Newman	
	Electronic Medical Record Custodian	Neighborhood Physicians Practice	
	Information Recipient	Dr Albert Davis	
	Visit Date	6/22/2015	
	Care Team Members	Dr Albert Davis Tracy Davis	
	Other Participants in event	Mr Rick Holler (Grand Parent) First Name: Rick Last Name: Holler Mr Matthew Newman (Spouse) First Name: Matthew Last Name: Newman (Mr Rick and Mr Matthew have the same address as Ms Alice)	
	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

The following data is part of the medical record details identifying the relevant clinical data captured as part of the visit.

A) Problems

Code	CodeSystem	Problem Name	Timing Information	Concern Status	Notes

Code	CodeSystem	Problem Name	Timing Information	Concern Status	Notes
59621000	SNOMED-CT	Essential hypertension (Disorder,)	10/5/2011 – Start Date	Active	
83986005	SNOMED-CT	Severe Hypothyroidism (Disorder)	12/31/2006 – Start Date	Active	
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, 6/1/2007 – End Date	Completed	
44054006	SNOMED-CT	Diabetes Mellitus Type 2 (Disorder)	Start Date – UNK, End Date – 6/22/2015	Completed	No history of diabetes mellitus type 2.

B) Encounter Diagnoses

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

Code	Code System	Vitals	Date	Value
3141-9	LOINC	Weight	7/22/2015 10:05 EST	96 kg
8130-5	LOINC	Body Temperature	7/22/2015 10:07 am EST.	99 degree F

D) Medications

Code	CodeSystem	Medication	Timing Information	Route	Frequency	Dose
309090	RxNorm	Ceftriaxone 100 MG/ML	6/22/2015 – Start Date End Date – 7/22/2015	Injectable	BID	1 unit
209459	RxNorm	Tylenol 500mg	6/22/2015 - Start Date, For 10 days	Oral	As needed	1 unit
576586	RxNorm	Darbepoetin Alfa 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, (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. Intermittent Fever Problem concern

G) 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

H) 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.