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. Sandra Glazer 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: Sandra Last Name: Glazer Middle Name: Jones Previous Name: Samantha 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
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	

CCDS Data Elements	Contextual Data Elements required for medical record encoding to C-CDA	Details	Additional Information
	Author/Legal Authenticator/Authenticator of Electronic Medical Record	Dr Henry Seven Time: 6/22/2015	
	System that generated the document	Community Health and Hospitals EMR	
	Informants	Frank Glazer (Spouse) First Name: Frank Last Name: Glazer	
	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 Robert Henry (Grand Parent) First Name: Robert Last Name: Henry Mr Frank Glazer(Spouse) – Mr Frank and Mr Robert have the same address information as Ms Sandra Glazer.	
	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.

Code	CodeSystem	Medication	Start Date	Route	Frequency	Dose
309090	RxNorm	Ceftriaxone 100 MG/ML	StartDate: 6/22/2015, End Date 6/24/2015	Injectable	BID	1 unit
47835	RxNorm	Vantin (cefpodoxime 100mg)	StartDate: 6/22/2015, End Date 6/24/2015	Oral	BID	1 unit
209459	RxNorm	Tylenol 500mg	StartDate: 6/22/2015, End Date 6/24/2015	Oral	As needed	1 unit
576586	RxNorm	Darbepoetin Alfa 0.5 MG/ML	StartDate: 6/22/2015, End Date 6/24/2015	Injectable	Once a week	1 unit
748747	RxNorm	Clindamycin 300mg	StartDate: 6/23/2015, End Date 6/24/2015	Oral	TID	1 unit
568809	RxNorm	Torsemide 20mg	StartDate: 6/23/2015, End Date 6/24/2015	Oral	Qd	1 unit
40144	RxNorm	Levothyroxine Sodium	StartDate: 6/23/2015, End Date 6/24/2015	Oral	QD	1 unit
668657	RxNorm	Prednisolone 10mg	Start Date :6/23/2015, End Date: 7/4/2015	Oral	QD	1 unit
860887	RxNorm	FenoFibric Acid 35 mg	StartDate: 6/24/2015, End Date: 7/4/2015	Oral	QHS	1 unit
541585	RxNorm	Mycophenolic Acid 360 mg	StartDate: 6/24/2015, End Date: 6/27/2015	Oral	BID	1 unit
977435	RxNorm	Everolimus 0.5 mg	StartDate: 6/24/2015, End Date: 7/20/2015	Oral	BID	1 unit
848958	RxNorm	Ciprofloxacin 2mg/ml	StartDate: 6/24/2015 , End Date: 7/24/2015	Oral	TID	1 unit

B) Problems

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

C) Encounter Diagnoses

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

D) Vital Signs

Code	Code System	Vitals	Date	Value
8302-2	LOINC	Height	6/22/2015	177 cm
3141-9	LOINC	Weight	6/22/2015	110 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
8130-5	LOINC	Body Temperature	6/23/2015 10:07 am EST.	99 degree F

Code	Code System	Vitals	Date	Value
8130-5	LOINC	Body Temperature	6/24/2015 10:07 am EST.	98 degree F

E) 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.

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. Iron deficiency Anemia 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
      iii. Progress Towards Goal of Body Temperature – Goal Achieved as of 6/24/2015

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.

I) 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.