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

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 [Medication Name].
    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. [Medication Name], the display name is optional.
    c. When a section is marked with [] , the entire section is optional. For e.g [Problems]
    d. 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]

    e. 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. 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. 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.]

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

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:	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)	
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
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	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.] – This section is optional in CarePlan.

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	StartDate: 6/22/2015, End Date 6/30/2015	Injectable	Two times daily	1 unit
209459 (SBD)	RxNorm	Tylenol 500mg	StartDate: 6/22/2015, End Date 6/30/2015	Oral	As needed	1 unit
731241 (SBD)	RxNorm	Aranesp 0.5 MG/ML	StartDate: 6/22/2015, End Date 6/30/2015	Injectable	Once a week	1 unit
284215 (SCD)	RxNorm	Clindamycin 300mg	StartDate: 6/23/2015, End Date 6/30/2015	Oral	Three times daily	1 unit
198371 (SCD)	RxNorm	Torsemide 20mg	StartDate: 6/23/2015, End Date 6/30/2015	Oral	Daily	1 unit
860886 (SCD)	RxNorm	FenoFibric Acid 35 mg	StartDate: 6/24/2015, End Date: 7/4/2015	Oral	At the hour of sleep	1 unit
485023 (SCD)	RxNorm	Mycophenolic Acid 360 mg	StartDate: 6/24/2015, End Date: 6/27/2015	Oral	Two times daily	1 unit
977434 (SCD)	RxNorm	Everolimus 0.5 mg	StartDate: 6/24/2015, End Date: 7/20/2015	Oral	Two times daily	1 unit
197511 (SCD)	RxNorm	Ciprofloxacin 250 mg	StartDate: 6/24/2015 , End Date: 7/24/2015	Oral	Three times daily	1 unit

B) [Problems] - This section is optional in CarePlan.

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]	Health concern status
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] – This section is optional in CarePlan.

Note: Encounter Diagnoses can be represented by either SNOMED-CT or ICD-10. So SUT can choose either the ICD-10 code or the SNOMED-CT code as appropriate from the table below based on the CodeSystem supported.

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
234348004	SNOMED-CT	Anemia of renal disease	6/22/2015	Community Health and Hospitals 1002, Healthcare Dr, Portland, OR-97266

D) [Vital Signs] – This section is optional in CarePlan.

Code	Code System	[Vital Sign Name]	Timing Informatiion	Value and Units
8302-2	LOINC	Height	6/22/2015 [10:05 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]

Code	Code System	[Vital Sign Name]	Timing Informatiion	Value and Units
8310-5	LOINC	Body Temperature	6/22/2015 [10:10 am EST]	Value=42 Units=Cel
8310-5	LOINC	Body Temperature	6/23/2015 [10:10 am EST]	Value=40 Units=Cel
8310-5	LOINC	Body Temperature	6/24/2015 [10:10 am EST]	Value=38 Units=Cel

E) Goals

(Visual Inspection – ATL's need to visually inspect the System Under Test (SUT) generated C-CDA for the Goals content.**)**

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, 38-39 degrees Celsius, Date-6/22/2015, Related problem reference is as follows]

Code	Code System	Description	Date	Status
64667001	SNOMED-CT	Interstitial pneumonia (disorder)	6/22/2015	Active

d. Keep weight under 95kg.

F) Health Concerns

(Visual Inspection – ATL's need to visually inspect the System Under Test (SUT) generated C-CDA for the Health Concerns content.**)**

a. Health Status – Chronic Sickness
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 – This section is optional in CarePlan per C-CDA IG, however it is required for 2015 Edition certification.

(Visual Inspection – ATL's need to visually inspect the System Under Test (SUT) generated C-CDA for the Health Status Evaluations and Outcomes content.**)**

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 – This section is optional in CarePlan per C-CDA IG, however it is required for 2015 Edition certification.

(Visual Inspection – ATL's need to visually inspect the System Under Test (SUT) generated C-CDA for the Intervention content.**)**

a. InterventionAct #1:
    i. Nutrition Recommendations:
        1. Follow dietary regime as discussed
        2. Read about nutrition as discussed
    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] – This section is optional in CarePlan. **(Visual Inspection** – ATL's need to visually inspect the System Under Test (SUT) generated C-CDA for the Discharge Instructions 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 > 42 degree Celsius or onset of chest pain/breathlessness contact Emergency.
    e. Come in once a month to get a checkup of your weight and iron deficiency.