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

Ambulatory Setting

1. **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

1. Test of 45 CFR 170.315 (b) (9)

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

1. 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]
   1. When a narrative or text block is surrounded by [ ] the entire narrative block is optional.
   2. When a column heading is surrounded by [ ] the data represented by the column is optional. For e.g. [ Service Delivery Location ]
   3. When a section is marked with [] , the entire section is optional. For e.g [Problems]
   4. 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 ] |

* 1. 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.

1. Additional clarifications are added with the keyword “**Note**”.
2. 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”.
3. 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.

1. **Header Data**

The following data is part of the medical record header identifying the contextual information necessary when exchanging data.

1. 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) |  |
| 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 |  |

1. 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  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 ] |

1. **Body Data**

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

1. [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] | 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 |
| 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 |

1. [Encounter Diagnoses] - This section is optional in CarePlan.

**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 |

1. [Vital Signs] - This section is optional in CarePlan.

| 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] |
| 8310-5 | LOINC | Body Temperature | 6/22/2015, [ 10:07 am EST ]. | Value=42  Units=Cel |

1. [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 | 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 |

1. Goals

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

* 1. Get rid of intermittent fever that is occurring every few weeks.
  2. Need to gain more energy to do regular activities.
  3. [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 |
| --- | --- | --- | --- | --- |
| 386661006 | SNOMED-CT | Fever (finding) | 6/22/2015 | Active |

* 1. Keep weight under 95kg.

1. Health Concerns

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

* 1. Health Status – Chronic Sickness
  2. [HealthCare Concerns refer to underlying clinical facts]
     1. HyperTension problem concern
     2. HypoThyroidism problem concern
     3. Vital Sign Weight Observation
     4. Intermittent Fever Problem concern

1. 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.**)**

* 1. Outcome Observation #1:
     1. [Refers to Goal Observation for Weight]
     2. [Refers to the Intervention Act #1]
     3. Progress Towards Goal of Weight – Goal Not Achieved as of 6/22/2015
  2. [Outcome Observation #2: ]
     1. Refers to Goal Observation for Body Temperature
     2. Refers to Intervention Act #2

1. 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.**)**

* 1. InterventionAct #1:
     1. Nutrition Recommendations:
        1. Follow dietary regime as discussed
        2. Read about nutrition as discussed
     2. [Refers to the Goal Observation for Weight.]
  2. [InterventionAct #2: ]
     1. Refers to the Medications entries
     2. Refers to the Goal Observation for Body Temperature.