
COV-HIE
Technical Infrastructure

Exhibits

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Version 4

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COV-HIE Technical Infrastructure

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Exhibits

Exhibit A - Summary of HITSP Capabilities

HITSP/CAP117 Communicate Ambulatory and Long Term Care Prescription This capability addresses interoperability requirements that support electronic prescribing in the ambulatory and long term care environment. The capability supports:

1. The transmittal of new or modified prescriptions
2. Transmittal of prescription refills and renewals
3. Communication of dispensing status
4. Access to formulary and benefit information

HITSP/CAP118 Communicate Hospital Prescription This capability addresses interoperability requirements that support electronic prescribing for inpatient orders that can occur within an organization or between organizations. The capability supports the transmittal of a new or modified prescription from a Hospital to an internal or external pharmacy. It also includes the optionality to access formulary and benefit information.

HITSP/CAP119 Communicate Structured Document This capability addresses interoperability requirements that support the communication of structured health data related to a patient in a context set by the source of the document who is attesting to its content. Several document content subsets, structured according to the HL7 CDA standard, are supported by this capability. The following are examples of the type of structured data that may be used:

1. Continuity of Care Document (CCD)
2. Emergency Department Encounter Summary
3. Discharge Summary (In-patient encounter and/or episodes of care)
4. Referral Summary Ambulatory (encounter and/or episodes of care)
5. Consultation Notes
6. History and Physical
7. Personal Health Device Monitoring Document
8. Healthcare Associated Infection (HAI) Report Document Document creators shall support a number of the HITSP specified coded terminologies as defined by specific content subsets specified in this capability.

HITSP/CAP120 Communicate Unstructured Document This capability addresses interoperability requirements that support the communication of a set of unstructured health data related to a patient in a context set by the source of the document who is attesting to its content. Two types of specific unstructured content are supported, both with a structured CDA header:

1. PDF-A supporting long-term archival
2. UTF-8 text

HITSP/CAP121

Communicate Clinical Referral Request

This capability addresses interoperability requirements that support provider-to-provider (clinical) referral request interaction. It allows the bundling of the referral request document with other relevant clinical

documents of interest by referencing such documents as shared by other capabilities such as: CAP119 Communicate Structured Document; CAP120 Communicate Unstructured Document; or CAP133 Communicate Immunization Summary.

HITSP/CAP122

Retrieve Medical Knowledge

This capability addresses the requirements to retrieve medical knowledge that is not patient-specific based on context parameters. The actual content delivered is not constrained by this capability; this capability focuses on providing the mechanism to ask for (query) and receive the medical knowledge.

HITSP/CAP123

Retrieve Existing Data

This capability supports queries for clinical data (e.g., common observations, vital signs, problems, medications, allergies, immunizations, diagnostic results, professional services, procedures and visit history).

HITSP/CAP124

Establish Secure Web Access

This capability is focused on providing a secured method to access information available from document repositories (e.g., Laboratory Report) in order to view them locally on a system. The chosen method for viewing the document content is through a web browser.

HITSP/CAP125

Retrieve Genomic Decision Support

This capability addresses interoperability requirements that support the communication of genetic and family history information and an assessment of genetic risk of disease for a patient.

HITSP/CAP126

Communicate Lab Results Message

This capability addresses interoperability requirements that support the sending of a set of laboratory test results. Ordering Providers of Care receive results as a laboratory results message. The communication of the order is out of scope for this capability. The content of these test results may be either or both: General Laboratory Test Results; Microbiology Test Results This capability may use content anonymization.

HITSP/CAP127

Communicate Lab Results Document

This capability addresses interoperability requirements that support the communication of a set of structured laboratory results related to a patient in a context set by the source of the document who is attesting to its content. Non-ordering Providers of Care access historical laboratory results as documents and "copy-to" Providers of Care may receive document availability notifications to retrieve such lab report documents. Lab Report content creators shall support HITSP specified coded terminologies as defined by specific content subsets specified in this Capability for: General Laboratory Test Results; Microbiology Test Results This capability may use content anonymization.

HITSP/CAP128

Communicate Imaging Information

This capability addresses interoperability requirements that support the communication of a set of imaging results (i.e., reports, image series from imaging studies) related to a patient in a context set. This is done by an Imaging System acting as the information source attesting to its content. This capability may use content anonymization.

HITSP/CAP129

Communicate Quality Measure Data

This capability addresses interoperability to support hospital and clinician collection and communication of patient encounter data to support the analysis needed to identify a clinician or hospital's results relative to an EHR-compatible, standards-based quality measure. Quality measures may include:

1. Patient-level clinical detail from which to compute quality measures. Patient level clinical data is compiled from both the local systems and from longitudinal data available through other sources such as a Health Information Exchange (HIE).
2. Patient-level quality data based upon clinical detail. The "patient-level quality data reports" are exported from EHRs or quality-monitoring applications at the point of care. This capability may use content anonymization. Pseudonymization, if needed, is supported by the Capability 138 Retrieve Pseudonym. This capability may use Value Set Sharing.

HITSP/CAP130

Communicate Quality Measure Specification

This capability addresses interoperability requirements for an EHR-compatible, standards-based quality measure. In the measure specification, needed patient encounter data elements are identified so they can be extracted from local systems and from longitudinal data available through other sources such as a Health Information Exchange (HIE). The measure specification also includes various sets of exclusion/inclusion criteria to identify which patients to include in calculation of the measure. This capability may use Value Set Sharing.

HITSP/CAP131 3

Update Immunization Registry

This capability addresses interoperability requirements that enable electronic communication of immunization data among clinicians, with patients, and with immunization registries as unsolicited structured patient immunization data. This capability may use content anonymization.

HITSP/CAP132

Retrieve Immunization Registry Information

This capability addresses interoperability requirements that support the query and retrieval of structured immunization data related to a patient's vaccination. The capability may use one of the following:

1. HL7V2 query with implicit Patient Identity resolution
2. HL7V2 query with explicitly Patient Identity resolution prior to query
3. HL7V3 Query for Existing Data The query for immunization documents from Capability 133 - Communicate Immunization Summary may also be used.

HITSP/CAP133

Communicate Immunization Summary

This capability addresses interoperability requirements to support the communication of structured health data related to a patient's vaccination history. This immunization document contains a history of administered vaccines with details such as lot number, who administered it, as well as other information related to the patient's care such as medical history, medications, allergies, vital signs.

HITSP/CAP135

Retrieve and Populate Form

This capability addresses interoperability requirements to support the upload of specific captured data (e.g. public health surveillance reportable conditions, healthcare associated infection reporting) to Public Health Monitoring Systems and Quality Organizations Systems. The forms presented may be pre-populated by information provided by the clinical or laboratory information systems to avoid manual re-entry. A number of supplemental information variables may be captured from within the user's clinical information system to improve the workflow and timeliness of required reporting. One or more types of form content may be supported:

1. Pre-population for Public Health Case Reports from Structured Documents using CDA
2. Pre-population for Quality Data from Structured Documents using CDA
3. No pre-population content Systems may optionally support the means to retrieve request for clarifications.

HITSP/CAP136

Communicate Emergency Alert

This capability addresses interoperability requirements to support multicast of non-patient specific notification messages about emergencies events, alerts concerning incidence of communicable diseases, alerts concerning population needs for vaccines and other generic alerts sent to an identified channel. The intended recipients are populations such as "all emergency departments in XXX county", "within a geographic area", etc. Note that this capability is not used to communicate patient-specific or identifiable data.

HITSP/CAP137

Communicate Encounter Information Message

This capability addresses interoperability requirements to send specific clinical encounter data among multiple systems. The content may be either or both:

1. Encounter Data Message
2. Radiology Results Message It may be used in conjunction with other capabilities such as those related to the communication of laboratory data. This capability includes optional anonymization of content.

HITSP/CAP138

Retrieve Pseudonym

This capability addresses interoperability requirements to support a particular type of anonymization that both removes the association with a data subject, and adds an association between a particular set of characteristics relating to the data subject and one or more pseudonyms. This enables a process of supplying an alternative identifier, which permits a patient to be referred to by a key that suppresses his/her actual identification information. The purpose of this capability is to offer a pseudonymization framework for situations that require the use of specific data without disclosing the specific identity of patients or providers. Pseudo-identifiers are intended to allow accessibility to clinical information, while safeguarding any information that may compromise the privacy of the individual patient or provider. However, unlike anonymization, the alternative identifier key can be used to re-identify the individuals whose data was used.

HITSP/CAP139

Communicate Resource Utilization

This capability specifies the message and content necessary to report utilization and status of health provider resources to systems supporting emergency management officials at local, state or national levels

who have a need to know the availability of hospital and other healthcare resources. The resource utilization information may be provided routinely or in response to a request.

HITSP/CAP140 Communicate Benefits and Eligibility This capability addresses interoperability requirements that support electronic inquiry and response from a patient's eligibility for health insurance benefits. The information exchanged includes the following:

1. A patient's identification (i.e., name, date of birth, and the health plan's member identification number)
2. Communication of a member's status of coverage and benefit information and financial liability
3. Access to information about types of services, benefits and coverage for various medical care and medications. It provides clinicians with information about each member's health insurance coverage and benefits.

HITSP/CAP141

Communicate Referral Authorization

This capability addresses interoperability requirements that support electronic inquiry and response to authorizing a patient (health plan member) to be referred for service by another provider or to receive a type of service or medication under the patient's health insurance benefits. The capability supports the transmittal of a patient's name and insurance identification number with the request for the type of service. It also includes the following optional requirements:

1. Identification of the type of service or medication requested for benefit coverage (does not guarantee payment by insurance provider)
2. Communication of a referral notification number or authorization number from the Payer System to the Provider System. It provides clinicians and pharmacists with information about each patient's medical insurance coverage and benefits. It may include information on referral or authorization permission.

HITSP/CAP142

Retrieve Communications Recipient

This capability addresses interoperability requirements that support access to a directory to identify one or more communication recipients in order to deliver alerts and bidirectional communications (e.g., public health agencies notifying a specific group of service providers about an event). The method and criteria by which individuals are added to a directory is a policy decision, which is out of scope for this construct.

HITSP/CAP143

Manage Consumer Preference and Consents

This capability addresses management of consumer preferences and consents as an acknowledgement of a privacy policy. This capability is used to capture a patient or consumer agreement to one or more privacy policies; where examples of a privacy policy may represent a consent, dissent, authorization for data use, authorization for organizational access, or authorization for a specific clinical trial. This capability also supports the recording of changes to prior privacy policies such as when a patient changes their level of participation or requests that data no-longer be made available because they have left the region.

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Exhibit B – Interoperability Specifications



Welcome to www.HITSP.org

The Healthcare Information Technology Standards Panel (HITSP) is a cooperative partnership between the public and private sectors. The Panel was formed for the purpose of harmonizing and integrating standards that will meet clinical and business needs for sharing information among organizations and systems.

PROGRAM OF WORK

[View by Topic](#) [View by Status](#) [View Complete Library](#)

	IS 01	Electronic Health Record (EHR) Laboratory Results Reporting The Electronic Health Records Laboratory Results Reporting Interoperability Specification defines specific standards to support the interoperability between electronic health records and laboratory systems and secure access to laboratory results and interpretations in a patient-centric manner.
	IS 02	Biosurveillance The Biosurveillance Interoperability Specification defines specific standards that promote the exchange of biosurveillance information among healthcare providers and public health authorities.
	IS 03	Consumer Empowerment The Consumer Empowerment and Access to Clinical Information via Networks Interoperability Specification defines specific standards needed to assist patients in making decisions regarding care and healthy lifestyles (i.e., registration information, medication history, lab results, current and previous health conditions, allergies, summaries of healthcare encounters and diagnoses). This Interoperability Specification defines specific standards needed to enable the exchange of such data between patients and their caregivers via networks.
	IS 04	Emergency Responder Electronic Health Record (ER-EHR) The Emergency Responder Electronic Health Record Interoperability Specification defines specific standards required to track and provide on-site emergency care professionals, medical examiner/fatality managers and public health practitioners with needed information regarding care, treatment or investigation of emergency incident victims.
	IS 05	Consumer Empowerment and Access to Clinical Information via Media The Consumer Empowerment and Access to Clinical Information via Media Interoperability Specification defines specific standards needed to assist patients in making decisions regarding care and healthy lifestyles (i.e., registration information, medication history, lab results, current and previous health conditions, allergies, summaries of healthcare encounters and diagnoses). This Interoperability Specification defines specific standards needed to enable the exchange of such data between patients and their caregivers via physical media or secure email exchange.
	IS 06	Quality The Quality Interoperability Specification defines specific standards needed to benefit providers by providing a collection of data for inpatient and ambulatory care and to benefit clinicians by providing real-time or near-real-time feedback regarding quality indicators for specific patients.
	IS 07	Medication Management The Medication Management Interoperability Specification defines specific standards to facilitate access to necessary medication and allergy information for consumers, clinicians, pharmacists, health insurance agencies, inpatient and ambulatory care, etc.
	IS 08	Personalized Healthcare The Personalized Healthcare Interoperability Specification describes family history and genoto/genomic lab order and results which are used to provide personalized treatment specific to genetic makeup.

Did You Know....

HITSP is a volunteer-driven, consensus-based organization.

HITSP Member Workspace
(password required)

Public Review and Comment

HITSP and its Stakeholders

Learn more about how HITSP interacts with . . .

- Consumers
- Government Representatives and Policy Makers
- Healthcare Providers
- Standards Developers
- Vendors

HITSP Specifications

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	IS 09	<p>Consultations and Transfers of Care The Consultations and Transfers of Care Interoperability Specification describes the information flows, issues and system capabilities that apply to: 1. a provider requesting and a patient receiving a consultation from another provider 2. a provider requesting a transfer of care for a patient and the receiving facility admitting the patient. It is intended to facilitate access to information necessary for consultations and transfers for consulting clinicians, referring clinicians, transferring facilities, receiving facilities and consumers.</p>
	IS 10	<p>Immunizations and Response Management The Immunizations and Response Management Interoperability Specification focuses on: 1) providing information about individuals who need to receive specific vaccines, drugs, or other interventions; 2) the ability to report, track, and manage administration of vaccines, drugs, isolation, and quarantine; 3) the ability to identify and electronically exchange information describing the treatment or prophylaxis status of populations; 4) the ability to exchange specific resource and supply chain data from public and private sectors.</p>
	IS 11	<p>Public Health Case Reporting The Public Health Case Reporting Interoperability Specification supports the bi-directional information exchanges of the Public Health Case Reporting process. It focuses on enabling more efficient data capture at the point of care while allowing for optimizing the information delivery format and content allowing for current SDO efforts to be finalized. In the absence of standards in structured content and associated Clinical Decision Support for alerts and information reporting criteria, this Interoperability Specification provides options for the secure communication of basic presentation preserving content to better automate the current paper-based information flows.</p>
	IS 12	<p>Patient – Provider Secure Messaging The Patient-Provider Secure Messaging Interoperability Specification describes the information flows, processes, and system capabilities that are required for patients to interact with their healthcare clinicians remotely using common computer technologies readily available in homes and other settings.</p>
	IS 77	<p>Remote Monitoring The Remote Monitoring Interoperability Specification addresses the information exchange requirements for the transfer of remote monitoring information from a device physically attached to or used by a patient in a location that is remote to the clinician to an Electronic Health Record (EHR) system and/or a Personal Health Record system.</p>
	IS 107	<p>EHR-Centric This Interoperability Specification consolidates all information exchanges and standards that involve an EHR System amongst the thirteen HITSP Interoperability Specifications in place as of the February 19, 2009 enactment of the American Recovery and Reinvestment Act (ARRA). This Interoperability Specification is organized as a set of HITSP Capabilities, with each Capability specifying a business service that an EHR system might address in one or more of the existing HITSP Interoperability Specifications (e.g., the Communicate Hospital Prescriptions Capability supports electronic prescribing for inpatient prescription orders). Greater detail on these Capabilities is provided as part this Interoperability Specification, with their underlying HITSP constructs referenced in the Complete Library on HITSP.org.</p>



December 18, 2008
Version 2.0

HITSP Emergency Responder Electronic Health Record Interoperability Specification

HITSP/IS04



Submitted to:

Healthcare Information Technology Standards Panel

Submitted by:

Provider Perspective Technical Committee
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July 8, 2009
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HITSP Emergency Care Summary Document Using IHE Emergency Department Encounter Summary (EDES) Component

HITSP/C28

HITSP

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1.0 INTRODUCTION

1.1 OVERVIEW

An Emergency Department (ED) summary document is the collection of data from multiple sources (such as physicians, nurses, technologists, etc.) recording the assessments and care delivered by the ED team in response to an ED visit. It is a summary of the patient's current health status and care tendered in the ED between arrival and ED departure. It is not the complete "ED Chart" that may be the legal document of care, but a collection of medical summaries

1.2 COPYRIGHT PERMISSIONS

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IHE materials used in this document have been extracted from relevant copyrighted materials with permission of Integrating the Healthcare Enterprise (IHE) International. Copies of this standard may be retrieved from the IHE Web Site at www.ihe.net.

1.4 REFERENCE DOCUMENTS

This section provides a list of key reference documents and background material.

A list of key reference documents and background material is provided in the table below. These documents can be retrieved from www.hitsp.org.

Table 1-1 Reference Documents

Reference Document	Document Description
HITSP Acronyms List	Lists and defines the acronyms used in this document
HITSP Glossary	Provides definitions for relevant terms used by HITSP documents
TN900 - Security and Privacy	TN900 is a reference document that provides the overall context for use of the HITSP Security and Privacy constructs
TN903 - Data Architecture	TN903 is a reference document that provides the overall context for use of the HITSP Data Architecture constructs

1.3 CONFORMANCE

This section describes the conformance criteria, which are objective statements of requirements that can be used to determine if a specific behavior, function, interface, or code set has been implemented correctly.

1.3.1 CONFORMANCE CRITERIA

In order to claim conformance to this construct specification, an implementation must satisfy all the requirements and mandatory statements listed in this specification, the associated HITSP Interoperability Specification, its associated construct specifications, as well as conformance criteria from the selected base and composite standards. A conformant system must also implement all of the required interfaces within the scope, subset or implementation option that is selected from the associated Interoperability Specification.

Claims of conformance may only be made for the overall HITSP Interoperability Specification or Capability with which this construct is associated.



1.3.2 CONFORMANCE SCOPING, SUBSETTING AND OPTIONS

A HITSP Interoperability Specification must be implemented in its entirety for an implementation to claim conformance to the specification. HITSP may define the permissibility for actor scoping, subsetting or implementation options by which the specification may be implemented in a limited manner. Such scoping, subsetting and options may extend to associated constructs, such as this construct. This construct must implement all requirements within the selected scope, subset or options as defined in the associated Interoperability Specification to claim conformance.

RELEASED FOR IMPLEMENTATION



2.0 COMPONENT DEFINITION

2.1 CONTEXT OVERVIEW

This Component is based upon the output developed by the Integrating the Healthcare Enterprise Patient Care Coordination Committee (IHE PCC). This Component specifies the use of the Emergency Department Encounter Summary (EDES), Technical Framework Supplement, Volume I, Revision 3.0, 2007-2008.

As stated in IHE PCC-TF:

The text for the PCC-TF specification begins here:

The ED Encounter Summary is a folder in XDS that defines a collection of documents. Separate content profiles must be created for the various kinds of documents that might be included to represent the various kinds of documents that might be found in the EDES Folder. These content profiles include:

- ED Triage Note – this document contains data compiled during the ED triage process
- ED Nursing Note – this document contains data compiled during the on-going care (after initial triage) of the ED patient
- Composite ED Triage and ED Nursing Note – this document can be used in lieu of individual triage and ED Nursing notes by implementers where both above documents may be consolidated into a single document
- ED Physician Note – this document is a summary view of ED physician documentation
- Prehospital Care Report – this document has been identified as a future work product and is on the PCC Roadmap for 2008
- EDR (Emergency Department Referral) – this document was developed in the 2006 IHE cycle to support referral of a patient to the emergency department
- Diagnostic Imaging Reports – shall be shared using XDS-I
- Lab Reports – Laboratory reports shall be shared using XD*-LAB
- Consultations – future document type specification
- Transfer Summary – future document type specification
- Summary of Death – future document type specification

The text for the PCC-TF specification ends here.

IHE has not defined all of the content profiles in the above list. This Component specifies the support for the ED Triage Note, ED Nursing Note and ED Physician Note.

2.1.1 COMPONENT CONSTRAINTS

Table 2-1 Component Constraints

Constraint Code	Constraint
No applicable constraints	

2.1.2 COMPONENT DEPENDENCIES

Dependencies are defined by the IHE Emergency Department Encounter Summary (EDES), Technical Framework Supplement. No additional dependencies are defined in this Component.



Table 2-2 Component Dependencies

Standard/HITSP Component	Depends On (Name of standard/HITSP Component that it depends on)	Dependency Type (Pre-condition, Post-condition, General)	Purpose (Reason for this dependency)
No applicable dependencies			

2.2 RULES FOR IMPLEMENTING

2.2.1 DATA MAPPING

C28[CT1-1] Implementations of this Component shall support the specification defined by the IHE PCC document; Emergency Department Encounter Summary (EDES), Technical Framework Supplement, Volume I, Revision 3.0, 2007-2008.

2.2.2 GUIDELINES AND EXAMPLES

See IHE PCC Emergency Department Encounter Summary (EDES), Technical Framework Supplement, Volume I, Revision 3.0, 2007-2008 for guidelines and examples.

2.3 STANDARDS

2.3.1 REGULATORY GUIDANCE

Table 2-3 Regulatory Guidance

Standard	Description
No applicable regulatory guidance	

2.3.2 SELECTED STANDARDS

Table 2-4 Selected Standards

Standard	Description
Integrating the Healthcare Enterprise (IHE) Patient Care Coordination (PCC) - Emergency Department Encounter Summary (EDES), Technical Framework Supplement, Volume I, Revision 3.0, 2007-2008	The IHE Patient Care Coordination Technical Framework (PCC TF) defines specific implementations (called Integration Profiles) of established standards to deal with integration issues that cross providers, patient problems or time. The Emergency Department Encounter Summary (EDES) enables the sharing of emergency department summary information between enterprises of a regional health network, and further describes how to map content in a CDA medical document into registry metadata. In the registry, healthcare providers publish pointers to documents stored in distributed repositories. Other healthcare providers may search and retrieve these and other documents. For more information visit www.ihe.net .

2.3.3 INFORMATIVE REFERENCE STANDARDS

Table 2-5 Informative Reference Standards

Standard Name	Description
No applicable informative reference standards	



3.0 APPENDIX

The following section includes relevant materials referenced throughout this document.

- A listing of all HITSP Constraints defined within this document.

3.1 HITSP CONSTRAINTS DEFINED IN THIS DOCUMENT

C28[CT1-1] Implementations of this Component shall support the specification defined by the IHE PCC document; Emergency Department Encounter Summary (EDES), Technical Framework Supplement, Volume I, Revision 3.0, 2007-2008.

RELEASED FOR IMPLEMENTATION



4.0 CHANGE HISTORY

The following sections provide the history of all changes made to this document.

4.1 DECEMBER 5, 2007

The changes in this cycle address the following comments:

536, 1218, 1220, and 1222

The full text of the comments along with the Technical Committee's disposition can be reviewed on the HITSP Public Web Site.

4.2 DECEMBER 13, 2007

Upon approval by the HITSP Panel on December 13, 2007, this document is now Released for Implementation.

4.3 AUGUST 20, 2008

This document has been modified to reflect the updated HITSP approach to categorizing standards as Regulatory Guidance, Selected Standards, and Informative References.

4.4 AUGUST 27, 2008

Upon approval by the HITSP Panel on August 27, 2008, this document is now Released for Implementation.

4.5 JUNE 30, 2009

Revised the document based on HITSP/TN903 Data Architecture

General Updates:

- Section 2.2.1 Data Mapping, added Data Constraint
- Appendix 3.0, addition link to C28 Emergency Care Summary Document Constraint
- Added constraint C28[CT1-1]

Minor editorial changes were made to this construct. Removed boilerplate text for simplification. The term "actor" was replaced with "interface".

4.6 JULY 8, 2009

Upon approval by the HITSP Panel on July 8, 2009, this document is now Released for Implementation.



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Volume 1

HIMSS and RSNA
Integrating the Healthcare Enterprise



IHE Patient Care Coordination

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Technical Framework Supplement
Volume I

Revision 3.0
2008-2009

Public Comment

- Preface to Volume I of the PCC Technical Framework
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DRAFT

Exhibit F - References:

[1] *Preparing to Implement HITECH: A State Guide for Electronic Health Information Exchange*, Second Annual Report from the State Alliance for E-Health.

[2] *HITSP EHR-Centric Interoperability Specification, HITSP/IS107*, by EHR-Centric Interoperability Specification (IS) Tiger Team, Version 1.0, July 8, 2009.

[3] *American Recovery and Reinvestment Act of 2009, Title XIII - Health Information Technology, Subtitle B—Incentives for the Use of Health Information Technology, Section 3013, State Grants to Promote Health Information Technology*, State Health Information Exchange Cooperative Agreement Program, Funding Opportunity Announcement, Office of the National Coordinator for Health Information Technology, Department of Health and Human Services, 2009.

The 2009 PQRI consists of 153 quality measures and 7 measures groups. For further information on the 2009 PQRI quality measures, click on the "**Measures/Codes**" link to the left;
<http://www.cms.hhs.gov/pqri/>

The HIPAA Privacy Rule specifies permitted uses and disclosures and individual rights related to protected health information. These provisions are found at 45 CFR [Part 160](#) and [Part 164](#), Subparts A and E. For more details, please refer to:
<http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/adminsimpretext.pdf>

The HIPAA Security Rule specifies a series of administrative, technical, and physical security procedures for covered entities to use to assure the confidentiality of electronic protected health information. These provisions are found at 45 CFR Part 160, and Part 164, Subparts A and C.C For more details, please refer to:
<http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/adminsimpretext.pdf>.

The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation (42 CFR Part 2) specifies confidentiality requirements for substance abuse treatment programs as defined by 42 CFR § 2.11 that are “federally assisted” as defined by 42 CFR § 2.12(b)). For more details, please refer to: <http://www.hipaa.samhsa.gov>.

6.1 DESCRIPTION OF STANDARDS

The following table contains descriptions of the selected standards from Section 4.1.2 above:

Table 6-1 Description of Standards

Standard	Description
Accredited Standards Committee (ASC) X12 270 and 271 Transaction Standards Version 4010, using the Insurance Subcommittee (X12N) Addenda 004010X92A1	Many of the version X12N 004010 Implementation Guides, including all of those adopted under HIPAA, have Addenda that contain updates -- only -- to the original Implementation Guides. These Addenda are identified as version 004010A1. Implementation Guide 004010X092A1 describes transactions for Health Care Eligibility Benefit Inquiry and Response. Implementation Guides are published by Washington Publishing Company. For more information visit www.wpc-edi.com .

Standard	Description
Accredited Standards Committee (ASC) X12 270 and 271 transaction standards version 4010, using the Insurance Subcommittee (X12N) Implementation Guides Version Reference Numbers 004010X92	Detailed Implementation Guides based on release 004010 of the X12 standards. These Implementation Guides provide details on the use of X12 standards to accomplish specific transaction functions. Some of the version 004010 Implementation Guides, but not all, have been adopted as Implementation Specifications under HIPAA. Implementation Guides are published by Washington Publishing Company. For more information visit www.wpc-edi.com .
Accredited Standards Committee (ASC) X12 270 Transaction Version Standards Release 004010	The objective of the Health Care Eligibility/Benefit Inquiry (270) is to provide for the exchange of eligibility inquiry to individuals within a health plan. This transaction can be used by healthcare providers to request coverage and payment information on the member/insured in a batch environment where real time processing is not required. This transaction is also used to provide additional patient eligibility information to support administrative reimbursement for healthcare products and services. This standard is required by HIPAA. For more information visit www.wpc-edi.com .
Accredited Standards Committee (ASC) X12 271 Transaction Version Standards Release 004010	The objective of the Health Care Eligibility, Coverage, or Benefit Information (271) is to provide for the response to eligibility inquiries about individuals within a health plan. This transaction can be used to receive coverage and payment information on a member/insured in a batch environment where real time processing is not required. This transaction is also used to provide additional patient eligibility information to support administrative reimbursement for healthcare products and services. This standard is required by HIPAA. For more information visit www.wpc-edi.com .
Accredited Standards Committee (ASC) X12 278 Transaction Version Standards Release 004010	The objective of the Health Care Service Review Request for Review and Response (278) is to provide for the exchange of service review requests from a healthcare provider to a health plan, and a corresponding response from the health plan to that healthcare provider. This transaction can be used by healthcare providers to request approval and coverage information on the patient for a particular service type or service. This standard is required by HIPAA. This standard is required by regulatory guidance. For more information visit www.wpc-edi.com .
Accredited Standards Committee (ASC) X12 278 Transactions Standard Version 4010, using the Insurance Subcommittee (X12N) Addenda 004010X94A1	Many of the version X12N 004010 Implementation Guides, including all of those adopted under HIPAA, have Addenda that contain updates -- only -- to the original Implementation Guides. These Addenda are identified as version 004010A1. Implementation Guide 004010X0941 describes transactions for Health Care Service Review Request for Review and Response. Implementation Guides are published by Washington Publishing Company. For more information visit www.wpc-edi.com . This standard is required by regulatory guidance. For more information visit www.wpc-edi.com .
Accredited Standards Committee (ASC) X12 278 transactions standard version 4010, using the Insurance Subcommittee (X12N) Implementation Guides Version Reference Numbers 004010X94	Detailed Implementations Guide based on release 004010 of the X12 standards. These Implementation Guides provide details on the use of X12 standards to accomplish specific transaction functions. Some of the version 004010 Implementation Guides, but not all, have been adopted as Implementation Specifications under HIPAA. This standard is required by regulatory guidance. Implementation Guides are published by Washington Publishing Company. For more information visit www.wpc-edi.com .
Accredited Standards Committee (ASC) X12 Standards Release 004010	Release (version) 004010 of the Accredited Standards Committee (ASC) X12 standards including the X12.5 Interchange Control, X12.6 Application Control Structure, 270 Eligibility, Coverage or Benefit Inquiry, 271 Eligibility, Coverage or Benefit Information and other control standards for the uniform electronic interchange of business transactions. Published by the Data Interchange Standards Association (DISA). For more information visit www.x12.org .
American Medical Association (AMA) Current Procedural Terminology (CPT) Fourth Edition (CPT-4); CPT Evaluation and Management Codes	A uniform coding system used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals. For more information visit www.ama-assn.org .
CDC Race and Ethnicity Code Sets	The U.S. Centers for Disease Control and Prevention (CDC) has prepared a code set for use in coding race and ethnicity data. This code set is based on current federal standards for classifying data on race and ethnicity, specifically the minimum race and ethnicity categories defined by the U.S. Office of Management and Budget (OMB) and a more detailed set of race and ethnicity categories maintained by the U.S. Bureau of the Census (BC). The main purpose of the code set is to facilitate use of federal standards for classifying data on race and ethnicity when these data are exchanged, stored, retrieved, or analyzed in electronic form. At the same time, the code set can be applied to paper-based record systems to the extent that these systems are used to collect, maintain, and report data on race and ethnicity in accordance with current federal standards. For more information visit www.cdc.gov .

Standard	Description
Council for Affordable Quality Health Care (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase I Operating Rules	Provide agreed-upon business rules and guidelines for using and processing eligibility inquiry and response transactions between providers and health plans; in particular those that have been adopted under HIPAA. For more information visit www.caqh.org .
Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase II #258 Normalizing Last Name Rule v2.0.0	Provides agreed-upon business rules and guidelines for using and processing eligibility inquiry and response transactions between providers and health plans; in particular those that have been adopted under HIPAA. For more information visit www.caqh.org .
Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase II #259 AAA Error Code Reporting Rule v2.0.0	Provides agreed-upon business rules and guidelines for using and processing eligibility inquiry and response transactions between providers and health plans; in particular those that have been adopted under HIPAA. For more information visit www.caqh.org .
Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase II #260 Eligibility Data Content Rule v2.0.0	Provides agreed-upon business rules and guidelines for using and processing eligibility inquiry and response transactions between providers and health plans; in particular those that have been adopted under HIPAA. For more information visit www.caqh.org .
Council for Affordable Quality Healthcare (CAQH) Phase II Core #270 Connectivity Rule v2.0.0	The CORE #270 Connectivity Rule v2.00 developed by CAQH/CORE Connectivity Subgroup. It includes the following: Scope definition, rationale and policy guidelines Message envelope and submitter authentication standards (payload agnostic) Basic conformance requirements for stakeholders in terms of the chosen standards Message envelope metadata names, syntax and semantics Message envelope schemas and examples of use Error handling Glossary of terms For further information visit www.caqh.org .
Federal Information Processing Standards (FIPS) Codes for the Identification of the States, the District of Columbia and the Outlying Areas of the United States, and Associated Areas Publication # 5-2, May, 1987	A set of two-digit numeric codes and a set of two-letter alphabetic codes for representing the 50 states, the District of Columbia and the outlying areas of the United States, and associated areas. The standard covers all land areas under the sovereignty of the United States, the freely associated states of Federated States of Micronesia and Marshall Islands, and the trust territory of Palau. For more information visit www.itl.nist.gov . NOTE: ASC X12 transactions and ASC X12N Implementation Guides do not allow use of this standard; instead they require use of the U.S. Postal Service's National Zip Code and Post Office Directory -- which provides similar alphabetic code values.
Food and Drug Administration (FDA) - Unique Ingredient Identifier (UNII)	Provides codes developed by FDA to uniquely identify all ingredients used in marketed medications in the United States. Each UNII is assigned based on molecular structure, manufacturing process, or other characteristics. UNII is part of the Federal Medication Terminologies. For more information visit www.fda.gov/oc/datacouncil/SRS.htm
Food and Drug Administration (FDA) - National Drug Code (NDC)	Provides drug codes for prescription medicine and insulin products. NDC is managed by the FDA and is part of the Federal Medication Terminologies. For more information visit www.fda.gov/cder/ndc/database/default.htm
Health Level Seven (HL7) Common Terminology Services (CTS) Release 1	The HL7 Common Terminology Services (HL7 CTS) defines an Application Programming Interface (API) that can be used when accessing terminological content. The CTS specification was developed as an alternative to a common data structure. Instead of specifying what an external terminology must look like, HL7 has chosen to identify the common functional characteristics that an external terminology must be able to provide. As an example, an HL7 compliant terminology service will need to be able to determine whether a given concept code is valid within the particular resource. Instead of describing a table keyed by the resource identifier and concept code, the CTS specification describes an Application Programming Interface (API) call that takes a resource identifier and concept code as input and returns a true/false value. Each terminology developer is free to implement this API call in whatever way is most appropriate for them. For more information visit www.hl7.org It describes a set of API calls that represent the core functionality that will be needed by basic HL7 Version 3 applications.

Standard	Description
Health Level Seven (HL7) HL7 Version 3 Standard: Clinical Document Architecture (CDA), Release 2	The HL7 Clinical Document Architecture is an XML-based document markup standard that specifies the structure and semantics of clinical documents for the purpose of exchange. CDA is one instantiation of HL7's Version 3.0 Reference Information Model (RIM) into a specific message format. Of particular focus for HITSP Interoperability Specifications are message formats for Laboratory Results and Continuity of Care (CCD) documents. Release 2 of the HL7 Clinical Document Architecture (CDA) is an extension to the original CDA document markup standard that specifies the structure and semantics of clinical documents for the purpose of exchange. CDA R2 includes a prose document in HTML, XML schemas, data dictionary, and sample CDA documents. CDA R2 further builds upon other HL7 standards beyond just the Version 3.0 Reference Information Model (RIM) and incorporates Version 3.0 Data Structures, Vocabulary, and the XML Implementation Technology Specifications for Data Types and Structures. For more information visit www.hl7.org .
Health Level Seven (HL7) Implementation Guide for CDA Release 2: Consultation Note	The HL7 Implementation Guide for CDA Release 2: Consultation Note defines additional constraints on the CDA Header and Body used in a Consultation document in the U.S. realm, and provides examples of conforming fragments in the body of the document and an example of a conforming XML instance. For more information visit www.hl7.org
Health Level Seven (HL7) Implementation Guide for CDA Release 2: History and Physical (H&P) Notes	The HL7 Implementation Guide for CDA Release 2: History and Physical (H&P) Notes defines additional constraints on the CDA Header and Body used in a History and Physical document in the U.S. realm, and provides examples of conforming fragments in the body of the document and an example of a conforming XML instance. For more information visit www.hl7.org
Health Level Seven (HL7) Implementation Guide: CDA Release 2 Continuity of Care Document (CCD), April 01, 2007	The Continuity of Care Document implementation guide describes constraints on the HL7 Clinical Document Architecture, Release 2 (CDA) specification in accordance with requirements set forward in ASTM E2369-05 Standard Specification for Continuity of Care Record (CCR). The resulting specification, known as the Continuity of Care Document (CCD), is developed as a collaborative effort between ASTM and HL7. It is intended as an alternate implementation to the one specified in ASTM ADJE2369 for those institutions or organizations committed to implementation of the HL7 Clinical Document Architecture. For more information visit www.hl7.org .
Health Level Seven (HL7) Standard Code Set CVX - Vaccines Administered	The CDC's National Center of Immunization and Respiratory Diseases (NCIRD) maintains the HL7 external code set CVX. The implementation of the HL7 standard for immunization data exchange is described in Chapter 4 of the HL7 standard. The codes in HL7 Version 2.3 table 0292, represented the initial content of the external CVX code set. Since vaccines have to be added to this table more quickly than new versions of HL7 are released, this document represents the most up-to-date version of the CVX code set. Items have been added. Others have been added for planning purposes, pending FDA approval. For more information visit http://www.cdc.gov/vaccines/programs/iis/stds/cvx.htm
Health Level Seven (HL7) Standard Code Set MVX - Manufacturers of Vaccines	The CDC's National Center for Immunization and Respiratory Diseases (NCIRD) maintains the HL7 external code set MVX. The implementation of the HL7 standard for immunization data exchange is described in Chapter 4 of the HL7 standard. The codes in HL7 Version 2.3 table 0227 represent the initial content of the external MVX code set. This document represents the most up-to-date version of the MVX code set. For more information visit http://www.cdc.gov/vaccines/programs/iis/stds/mvx.htm
Health Level Seven (HL7) V3 RBAC, R1-2008, HL7 Version 3 Standard: Role Based Access Control (RBAC) Healthcare Permissions Catalog, Release 1, February 2008	The Healthcare Permission Catalog provides the necessary content for creating interoperable roles facilitating inter-organizational communications and information sharing among healthcare organizations and their business partners. For more information visit www.hl7.org .
Health Level Seven (HL7) Version 2.3.1 Chapter 2 Control, Chapter 3 Patient Administration	The HL7 Version 2.3.1 Messaging Standard is an application protocol for electronic data exchange in healthcare. It and prior versions have widespread use in the U.S. and internationally. Both message formats and value sets/code tables are contained in the standard. For more information visit www.hl7.org .
Health Level Seven (HL7) Version 2.5	The HL7 Version 2.5 Messaging Standard is an application protocol for electronic data exchange in healthcare. It and prior versions have widespread use in the U.S. and internationally. Both message formats and value sets/code tables (e.g., diagnosis type, gender, patient class, result status, specimen collection method, abnormal flags, observation result status codes interpretation, timestamp format) are contained in the standard. Of particular focus for HITSP Interoperability Specifications are message formats described in Chapters 2, 3, 5, and 7 including patient demographic (ADT) and lab result reporting. These are also used within composite standards from IHE for Patient Identity Cross-Referencing and Feed (PIX), Patient Demographics Query (PDQ), and Acknowledgements. For more information visit www.hl7.org .

Standard	Description
Health Level Seven (HL7) Version 2.5, Chapter 2 Control, Chapter 3 Patient Administration, Chapter 5 - Query	The HL7 Version 2.5 Messaging Standard is an application protocol for electronic data exchange in healthcare. It and prior versions have widespread use in the U.S. and internationally. Both message formats and value sets/code tables (e.g., diagnosis type, gender, patient class, result status, specimen collection method, abnormal flags, observation result status codes interpretation, and timestamp format) are contained in the standard. For more information visit www.hl7.org .
Health Level Seven (HL7) Version 3.0 Vocabularies and Value Sets	The HL7 Version 3.0 Messaging Standard is an application protocol for electronic data exchange in healthcare. Version 3.0 is based on a Reference Information Model (RIM); which is used to instantiate various message formats. Value sets/code tables are contained in the standard. For more information visit www.hl7.org .
Health Level Seven (HL7) Version 3.0 Privacy Consent related specifications RCMR_RM010001 - Data Consent	The Data Consent RMIM captures the data and associations needed to (1) record or report a consumers consent or dissent to authorize the access, collection, use, or disclosure of personally identifiable information; (2) convey a providers request or intent to override a patients recorded consent or dissent; (3) convey a type of consent directive associated with a privacy policy; or (4) to record or report a consumers consent directive, which is to be applied to future access, collection, use or disclosure of personally identifiable information. For more information visit www.hl7.org .
Integrating the Healthcare Enterprise (IHE) Exchange of Personal Health Record Content (XPHR)	The Exchange of Personal Health Record Content (XPHR) integration profile describes the content and format of summary information extracted from a PHR system used by a patient for import into healthcare provider information systems, and visa versa. The purpose of this profile is to support interoperability between PHR systems used by patients and the information systems used by healthcare providers. This profile does not address all the data exchange requirements of PHR systems. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Volume 2 Supplement 2007 2008 Cross-Enterprise User Assertion (XUA)	The Cross-Enterprise User Assertion Profile (XUA) provides a means to communicate claims about the user identity of an authenticated principal (user, application, system) in transactions that cross enterprise boundaries. To provide accountability in these cross enterprise transactions there is a need to identify the requesting user in a way that the receiver can make access decisions and proper audit entries. The XUA Profile supports enterprises that have chosen to have their own user directory with their own unique method of authenticating the entities, and others that may have chosen to use a third party to perform the authentication. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Revision 5.0 or later, Cross Enterprise Sharing of Scanned Documents (XDS-SD) Integration Profile	This profile defines how to store healthcare metadata in clinical documents, including patient identifiers, demographics, encounter, order or service information, represented within a structured HL7 CDA R2 header, with a PDF or plaintext formatted document containing clinical information. For more information visit www.ihe.net to retrieve Volume 1, and Volume 2 of the framework.
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Revision 4.0 or later, Audit Trail and Node Authentication Profile (ATNA)	Audit Trail and Node Authentication (ATNA) establishes the characteristics of a Basic Secure Node. It describes the security environment (user identification, authentication, authorization, access control, etc.) assumed for the node so that security reviewers may decide whether this matches their environments. It defines basic auditing requirements for the node. It defines basic security requirements for the communications of the node using TLS or equivalent functionality. It establishes the characteristics of the communication of audit messages between the Basic Secure Nodes and Audit Repository nodes that collect audit information. This integration profile has been designed so that specific domain frameworks may extend it through an option defined in the domain specific technical framework. Extensions are used to define additional audit event reporting requirements, especially actor specific requirements. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Revision 4.0 or later, Consistent Time (CT) Integration Profile	The Consistent Time Integration Profile (CT) provides a means to ensure that the system clocks and time stamps of the many computers in a network are well synchronized. This profile specifies synchronization with a median error less than 1 second. This is sufficient for most purposes. The current version of the ITI-TF Final Text, specifies the IHE CT Integration Profile, and other transactions defined and implemented as of October 10, 2008. The latest version of the IHE Technical Framework is available at www.ihe.net .

Standard	Description
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Revision 4.0 or later, Audit Trail and Node Authentication (ATNA) Integration Profile, Section 9.1 Authentication	Audit Trail and Node Authentication (ATNA) establishes the characteristics of a Basic Secure Node. It describes the security environment (user identification, authentication, authorization, access control, etc.) assumed for the node so that security reviewers may decide whether this matches their environments. It defines basic auditing requirements for the node. It defines basic security requirements for the communications of the node using TLS or equivalent functionality. It establishes the characteristics of the communication of audit messages between the Basic Secure Nodes and Audit Repository nodes that collect audit information. This integration profile has been designed so that specific domain frameworks may extend it through an option defined in the domain specific technical framework. Extensions are used to define additional audit event reporting requirements, especially actor specific requirements. The latest version of the IHE Technical Framework is available at www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Revision 5.0 or later, Patient Demographics Query (PDQ) Integration Profile	Provides ways for multiple distributed applications to query a central patient information server for a list of patients, based on user-defined search criteria, and retrieve a patients demographic (and, optionally, visit or visit-related) information directly into the application. For more information visit www.ihe.net
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Supplement 2008 - 2009, Pediatric Demographics, Draft for Trial Implementation (August 22, 2008)	The experience of immunization registries and other public health population databases has shown that matching and linking patient records from different sources for the same individual person in environments with large proportions of pediatric records requires additional demographic data. Pediatric Demographics makes use of the following six additional demographic fields to aid record matching in databases with many pediatric records. The latest version of the IHE Technical Framework is available at www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework, Revision 4.0 or later, Personnel White Pages profile	The Personnel White Pages (PWP) Profile provides access to basic directory information on human workforce members to other workforce members within the enterprise. This information has broad use among many clinical and non-clinical applications across the healthcare enterprise. This Personnel White Pages Profile specifies a method of finding directory information on the User Identities (user@realm) supplied by the Enterprise User Authentication (EUA) Integration Profile. For more information, visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Supplement 2008-2009 Sharing Value Sets (SVS)	The Sharing Value Sets (SVS) profile provides a means through which healthcare systems producing clinical or administrative data, such as diagnostic imaging equipment, laboratory reporting systems, primary care physician office EMR systems, or national healthcare record systems, can receive a common, uniform nomenclature managed centrally. Shared nomenclatures are essential to achieving semantic interoperability. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Revision 4.0, Section 10 Cross-Enterprise Document Sharing (XDS.a)	The IHE IT Infrastructure Technical Framework defines specific implementations of established standards to achieve integration goals that promote appropriate sharing of health information to support optimal patient care. Section 10, Cross-Enterprise Document Sharing facilitates the registration, distribution and access across health enterprises of patient electronic health records. IHE Integration Profiles offer a common language that healthcare professionals and vendors may use in communicating requirements for the integration of products. The current version of the ITI-TF, rev. 4.0 for Final Text, specifies the IHE transactions defined and implemented as of August 22, 2007. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Revision 4.0 - Registry Stored Query Transaction for XDS Profile Supplement [ITI-18]	The IHE IT Infrastructure Technical Framework defines specific implementations of established standards to achieve integration goals that promote appropriate sharing of health information to support optimal patient care. IHE Integration Profiles offer a common language that healthcare professionals and vendors may use in communicating requirements for the integration of products. The Registry Stored Query Transaction Trial Implementation Supplement specifies an IHE transaction that provides optimization and implementation simplification. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Supplement 2008-2009, Cross-Community Access (XCA), Trial Implementation, October 10, 2008	The IHE IT Infrastructure Technical Framework defines specific implementations of established standards to achieve integration goals that promote appropriate sharing of health information to support optimal patient care. IHE Integration Profiles offer a common language that healthcare professionals and vendors may use in communicating requirements for the integration of products. The trial implementation version of the XCA Supplement to the ITI-Technical Framework specifies the IHE transactions that support access between communities in a manner compatible with the XDS Integration profile. For more information visit www.ihe.net .

Standard	Description
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Volume 2 Supplement 2007 2008 Cross-Enterprise Document Sharing-B (XDS.b)	The Cross-Enterprise Document Sharing-B Profile (XDS.b) supplement provides a new implementation choice for the Cross-Enterprise Document Sharing (XDS) Integration Profile based on use of the Web Services and ebXML Reg/Rep standards that is consistent with current developments and best practices in the industry. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Revision 4.0 or later, Patient Identifier Cross-Referencing Integration Profile (PIX)	The Patient Identifier Cross-referencing Integration Profile (PIX) is targeted at healthcare enterprises of a broad range of sizes (hospital, a clinic, a physician office, etc.). It supports the cross-referencing of patient identifiers from multiple Patient Identifier Domains via the following interactions: 1) The transmission of patient identity information from an identity source to the Patient Identifier Cross-reference Manager. 2) The ability to access the list(s) of cross-referenced patient identifiers either via a query/response or via update notification. By specifying the above transactions among specific actors, this integration profile does not define any specific enterprise policies or cross-referencing algorithms. By encapsulating these behaviors in a single actor, this integration profile provides the necessary interoperability while maintaining the flexibility to be used with any cross-referencing policy and algorithm as deemed adequate by the enterprise. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Revision 4.0 XCA Supplement	The IHE IT Infrastructure Technical Framework defines specific implementations of established standards to achieve integration goals that promote appropriate sharing of health information to support optimal patient care. IHE Integration Profiles offer a common language that healthcare professionals and vendors may use in communicating requirements for the integration of products. The trial implementation version of the XCA Supplement to the ITI-TF, rev. 4.0 Final Text, specifies the IHE transactions that support access between communities in a manner compatible with the XDS Integration profile. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Supplement 2007 - 2008 Basic Patient Privacy Consents (BPPC) Trial Implementation	The Basic Patient Privacy Consents (BPPC) profile provides a mechanism to record the patient privacy consent(s), a method to mark documents published to XDS with the patient privacy consent that was used to authorize the publication, and a method for XDS Consumers to use to enforce the privacy consent appropriate to the use. This profile complements XDS by describing a mechanism whereby an XDS Affinity Domain can develop and implement multiple privacy policies, and describes how that mechanism can be integrated with the access control mechanisms supported by the XDS Actors (e.g., systems). There are two key parts of the profile: 1) It provides a document content specification for capturing a patient acknowledgement of a privacy consent policy or policies. 2) It describes the method by which XD* Actors can enforce the privacy policies determined by the document confidentialityCode related to the patient privacy consents. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) IT Infrastructure Technical Framework (ITI-TF) Supplement 2008-2009 Document-based Referral Request (DRR)	This profile describes how to relate a referral request document with relevant clinical documents, communicate the group of documents to a referral dispatcher with an optional online transaction to trigger the referral and communicate acceptance. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) Laboratory Technical Framework Volume 3 (LAB TF-3) Document-based Transactions, Revision 2.0 - For Trial Implementation, August 16, 2007	The IHE Laboratory Technical Framework introduces a content Integration Profile Sharing Laboratory Reports (LAB TF-3) that describes a clinical laboratory report as a human-readable electronic document. This document, which may also contain data in a machine-readable format and contains the complete set of final results, produced by a clinical laboratory in fulfillment of one or more test orders for a patient. This document is focused on the sharing of sets of laboratory results in the form of a laboratory report structured document, and is not intended to address ordering or return of laboratory results to the ordering provider. For more information visit www.ihe.net .
Integrating the Healthcare Enterprise (IHE) Patient Care Coordination (PCC), Revision 4.0, 2008 - 2009, Cross-Enterprise Sharing of Medical Summaries (XDS-MS) Integration Profile	The IHE Patient Care Coordination Technical Framework (PCC TF) defines specific implementations (called Integration Profiles) of established standards to deal with integration issues that cross providers, patient problems or time. The Cross Enterprise Document Sharing of Medical Summaries (XDS-MS) Integration Profile enables sharing of health information between enterprises of a regional health network, and further describes how to map content in a CDA medical document into registry metadata. In the registry, healthcare providers publish pointers to documents stored in distributed repositories. Other healthcare providers may search and retrieve these and other documents. For more information visit www.ihe.net .

Standard	Description
Integrating the Healthcare Enterprise (IHE) Patient Care Coordination (PCC) - Emergency Department Encounter Summary (EDES), Technical Framework Supplement, Volume I, Revision 3.0, 2007-2008	The IHE Patient Care Coordination Technical Framework (PCC TF) defines specific implementations (called Integration Profiles) of established standards to deal with integration issues that cross providers, patient problems or time. The Emergency Department Encounter Summary (EDES) enables the sharing of emergency department summary information between enterprises of a regional health network, and further describes how to map content in a CDA medical document into registry metadata. In the registry, healthcare providers publish pointers to documents stored in distributed repositories. Other healthcare providers may search and retrieve these and other documents. For more information visit www.ihe.net .
International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)	The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS), describes the classification of inpatient procedures for statistical purposes and for the indexing of healthcare records by procedures. ICD-10-PCS is a procedural coding system managed by the Centers for Medicare and Medicaid Services (CMS). For more information visit www.cms.hhs.gov . Note: While ICD-10 is not deployed in US installations, we recognize the need to move toward new releases of coded values.
International Classification of Diseases, 10th Revision, Related Health Problems (ICD-10-CM)	The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), describes the classification of morbidity information for statistical purposes and for the indexing of healthcare records by diseases. The National Center for Health Statistics (NCHS), the Federal agency responsible for use of the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) in the United States, developed a clinical modification of the classification for morbidity purposes. For more information visit www.cdc.gov/nchs . Note: While ICD-10 is not deployed in US installations, we recognize the need to move toward new releases of coded values.
International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM)	The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes I, II (diagnoses) and III (procedures) describes the classification of morbidity information for statistical purposes and for the indexing of healthcare records by diseases and procedures. For more information visit www.cdc.gov/nchs .
International Classification of Functioning, Disability and Health (ICF)	The International Classification of Functioning, Disability and Health, known more commonly as ICF, is a classification of health and health-related domains. These domains are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation. Since an individuals functioning and disability occurs in a context, the ICF also includes a list of environmental factors. See www.who.int/classifications/icf/en/ .
International Health Terminology Standards Development Organisation (IHTSDO) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT)	SNOMED CT consists of a technical design, core content architecture, and Core content. SNOMED CT Core content includes the technical specification of SNOMED CT and fully integrated multi-specialty clinical content. The Core content also includes a concepts table, description table, relationships table, history table, ICD-9-CM mapping, and Technical Reference Guide. Additionally, SNOMED CT provides a framework to manage language dialects, clinically relevant subsets, qualifiers and extensions, as well as concepts and terms unique to particular organizations or localities. For more information visit www.ihtsdo.com .
International Organization for Standardization (ISO) ISO 3166-1	The International Standard for country codes. The purpose of ISO 3166 is to establish codes for the representation of names of countries, territories or areas of geographical interest, and their subdivisions. For more information visit www.iso.org .
International Organization for Standardization (ISO) PDF/A ISO 19005-1b. Document management - Electronic document file format for long-term preservation - Part 1: Use of PDF (PDF/A)	Specifies how to use the Portable Document Format (PDF) 1.4 for long-term preservation of electronic documents. It is applicable to documents containing combinations of character, raster and vector data. For more information visit www.iso.org .
Internet Engineering Task Force (IETF) Network Time Protocol (Version 3) Specification, Implementation and Analysis, "Request for Comment" (RFC) #1305, March, 1992	Describes the Network Time Protocol (NTP): the mechanisms to synchronize time and coordinate time distribution in a large, diverse internet operating at rates from mundane to lightwave. For more information visit www.ietf.org .
Internet Engineering Task Force (IETF) Simple Network Time Protocol (SNTP) Version 4, "Request for Comment" (RFC) #2030, October, 1996	Describes the Simple Network Time Protocol (SNTP) Version 4, which is an adaptation of the Network Time Protocol (NTP). SNTP can be used when the ultimate performance of the full NTP implementation is not needed or justified. When operating with current and previous NTP and SNTP versions, SNTP Version 4 involves no changes to the NTP specification or known implementations, but is rather a clarification of certain design features of NTP. For more information visit www.ietf.org .

Standard	Description
Internet Engineering Task Force (IETF) Tags for Identifying Languages, "Request for Comment" (RFC) # 4646, September, 2006	This document describes the structure, content, construction, and semantics of language tags for use in cases where it is desirable to indicate the language used in an information object. It also describes how to register values for use in language tags and the creation of user-defined extensions for private interchange. This document, in combination with RFC 4647, replaces RFC 3066, which replaced RFC 1766. For more information visit www.ietf.org/rfc/rfc4646.txt .
Logical Observation Identifiers Names and Codes (LOINC)	A database of universal identifiers for laboratory and other clinical observations. The laboratory portion of the LOINC database contains the usual categories of chemistry, hematology, serology, microbiology (including parasitology and virology), and toxicology; as well as categories for drugs and the cell counts typically reported on a complete blood count or a cerebrospinal fluid cell count. Antibiotic susceptibilities are a separate category. The clinical portion of the LOINC database includes entries for vital signs, hemodynamics, intake/output, EKG, obstetric ultrasound, cardiac echo, urologic imaging, gastroendoscopic procedures, pulmonary ventilator management, selected survey instruments, and other clinical observations. For more information visit www.loinc.org .
National Cancer Institute (NCI) Thesaurus	The NCI Thesaurus is a reference terminology and biomedical ontology used in a growing number of NCI and other systems. It covers vocabulary for clinical care, translational and basic research, and public information and administrative activities. The NCI Thesaurus provides definitions, synonyms, and other information on nearly 10,000 cancers and related diseases, 8,000 single agents and combination therapies, and a wide range of other topics related to cancer and biomedical research. It is part of the Federal Medication Terminologies. For more information visit www.cancer.gov .
National Library of Medicine (NLM) Unified Medical Language System (UMLS) RxNorm	Provides standard names for (1) clinical drugs and (2) drug dose forms as administered to a patient. Also provides links from clinical drugs, both branded and generic, to their active ingredients, drug components (active ingredient + strength), and related brand names. Food and Drug Administration (FDA) National Drug Codes (NDCs) for specific drug products and many of the drug vocabularies commonly used in pharmacy management and drug interaction software are additionally linked to RxNorm. RxNorm is a part of the Federal Medication Terminologies. For more information visit www.nlm.nih.gov
National Uniform Billing Committee (NUBC) Uniform Bill Version 1992 (UB-92) Current UB Data Specification Manual Field 22, Patient Discharge Status, Codes	A code set identifying status of patient discharge on an institutional claim (e.g., inpatient, outpatient, hospice, home care). For more information visit www.nubc.org
Organization for the Advancement of Structured Information Standards (OASIS) Emergency Data Exchange Language (EDXL) Distribution Element (DE) Version 1.0	This is a standard message distribution framework for data sharing among emergency information systems using the XML-based Emergency Data Exchange Language (EDXL). This format may be used over any data transmission system, including but not limited to the SOAP HTTP binding. It is a routing element intended to route payloads of any kind, including other OASIS emergency message standards such as CAP, HAVE and Resource Messaging, but also any of the HITSP constructs, NIEM IEPDS, etc. It is designed to be provisioned by core services to route based on geography, incident type, agency type, or level of government. It can also be provisioned with access control and other security data. For more information visit docs.oasis-open.org/emergency/edxl-de/v1.0/EDXL-DE_Spec_v1.0.pdf .
Organization for the Advancement of Structured Information Standards (OASIS) Security Assertion Markup Language (SAML) Core v2.0 OASIS Standard; ITU-T X.1141	SAML, developed by the Security Services Technical Committee of OASIS, is an XML-based framework for communicating user authentication, entitlement, and attribute information. As its name suggests, SAML allows business entities to make assertions regarding the identity, attributes, and entitlements of a subject (an entity that is often a human user) to other entities, such as a partner company or another enterprise application. For more information visit www.oasis-open.org .
Organization for the Advancement of Structured Information Standards (OASIS) WS-Trust Version 1.3, March 2007	Defines extensions that build on [WS-Security] to provide a framework for requesting and issuing security tokens, and to broker trust relationships. Defines Security Token Service (STS) model for security tokens including requesting, issuing, renewing, canceling and validating. For more information visit www.oasis-open.org .
Organization for the Advancement of Structured Information Standards (OASIS) eXtensible Access Control Markup Language (XACML), ITU-T Recommendation X.1142, February 2005	The Organization for the Advancement of Structured Information Standards (OASIS) standards group developed the eXtensible Access Control Markup Language (XACML) as a language to express and evaluate access decisions. The XACML technical specification includes a profile for RBAC using XACML that complies with the ANSI RBAC standard. The HL7 RBAC Permission Catalog provides a standard vocabulary that can be used for cross-enterprise access control. For more information visit www.oasis-open.org .

Standard	Description
Organization for the Advancement of Structured Information Standards (OASIS) Emergency Data Exchange Language (EDXL) Hospital Availability Exchange (HAVE) Version 1.0	Specifies an XML-formatted document that allows healthcare provider organizations to communicate specific utilization information and status of a facility (e.g., hospital, trauma center, nursing home) and its resources; including bed capacity and availability, emergency department status, the available service coverage, and the status of a hospital's facility and operations. HAVE is initially intended for use in disaster or emergency situations. For more information visit www.oasis-open.org .
Organization for the Advancement of Structured Information Standards (OASIS) Common Alerting Protocol (CAP) V1.1, October 2005	This is a simple but general format for exchanging all-hazard emergency alerts and public warnings over all kinds of networks. CAP allows a consistent warning message to be disseminated simultaneously over many different warning systems, thus increasing warning effectiveness while simplifying the warning task. CAP also facilitates the detection of emerging patterns in local warnings of various kinds, such as might indicate an undetected hazard or hostile act. And CAP provides a template for effective warning messages based on best practices identified in academic research and real-world experience. For more information visit www.oasis-open.org
Unified Code for Units of Measure (UCUM)	A code system intended to include all units of measures being contemporarily used in international science, engineering, and business. The purpose is to facilitate unambiguous electronic communication of quantities together with their units. The focus is on electronic communication, as opposed to communication between humans. For more information visit aurora.regenstrief.org .
United States Postal Service (USPS) Postal Codes	United States Postal Service (USPS) Postal Codes
VHA National Drug File Reference Terminology (NDF-RT) Formulary	Provides standard names for (1) mechanism of action, (2) Physiologic Effect and (3) Structural Class. NDF-RT is part of the Federal Medication Terminologies. For more information visit www.cancer.gov/cancertopics/terminologyresources/page5

Value Set	Link
CPT-4	Identify medical services and procedures furnished by physicians and other health care professionals www.ama.org
Race & Ethnicity	www.CDC.gov http://www.cdc.gov/phn/library/documents/pdf/CDC%20Race%20and%20Ethnicity%20Code%20Set%20Version%201.pdf
(ASC) x12	Eligibility coverage or benefit information www.x12.org
Codes for Vaccines Administered	CVX code www.CDC.gov <i>See Tables 2-88 and 2-90</i>
Codes for Identification of States	www.itl.nist.gov www.usps.com http://zip4.usps.com
National Drug Code	www.fda.gov
Health Level Seven V2 & 3	Reference Information Model www.hl7.org
SNOMED CT	www.nlm.nih.gov
Logical Observation identifiers Names and Codes (LOINC)	Lab and clinical for vital signs, hemo-dynamics, intake/output, EKG, obstetric ultrasound, cardiac echo, urologic imaging, etc. www.loinc.org <i>See Tables 2-97, 2-99 and 2-101</i>
National Cancer Institute (NCI) Thesaurus	http://ncit.nci.nih.gov/
National Library of Medicine (NLM) Unified Medical Language System (UMLS)	www.nlm.nih.gov
National Uniform Billing committee (NUBC)	Http://www.nubc.org <i>See Table 2-28</i>

Exhibit G - 2009 PQRI

Inpatient Hospital Quality Measures
(Data Submission and Hospital Compare Details for Calendar Year 2009 Discharges)

The purpose of this document is to provide a reference guide on submission and Hospital Compare details for Quality Improvement Organizations (QIOs) and Providers for the National Quality Inpatient Measures.

All **measure sets** (AMI, PN, HF, SCIP, CAC and PR) contained in the *Specifications Manual for National Hospital Quality Inpatient Measures* are listed.

The first column contains the **Measure Identifier** followed by the **Measure Title**.

When required submission began

Who data is collected for:

If/when measure is displayed on Hospital Compare Website:

Inpatient Hospital Quality Measures	*Required Submission	Collected For:	**Hospital Compare Scheduled Release			
			Mar-09	Jun-09	Sep-09	Dec-09
Acute Myocardial Infarction (AMI)						
AMI-1 Aspirin at Arrival ¹	11/2003	CMS/TJC	✓	✓	✓	✓
AMI-2 Aspirin Prescribed at Discharge	11/2003	CMS/TJC	✓	✓	✓	✓
AMI-3 ACEI or ARB for LVSD ¹	11/2003	CMS/TJC	✓	✓	✓	✓
AMI-4 Adult Smoking Cessation Advice/Counseling ²	3Q 2006	CMS/TJC	✓	✓	✓	✓
AMI-5 Beta-Blocker Prescribed at Discharge ¹	11/2003	CMS/TJC	✓	✓	✓	✓

A **footnote** has been added to designate when measures became part of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. A table has been included at the bottom of the final page to further explain the footnotes.

Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Measures
¹ Measure included in '10 measure starter set'
² Additional measure added to original '10 measure starter set' to make '21 measure expanded set' (CMS Reg. 1488-FC, posted 08/2006)
³ Measure finalized in CY 2007 OPPS Final Rule (CMS Regulation 1506-FC, posted 11/2006)
⁴ Measure finalized in FY 2008 IPPS Final Rule (CMS Regulation 1533-FC, posted 08/2007)
⁵ Measure finalized in CY 2008 OPPS Final Rule (CMS Regulation 1392-FC, posted 11/2007)
⁶ Measure finalized in CY 2009 IPPS Final Rule (CMS Regulation 1390-F, posted 8/2008)
⁷ Measure finalized in CY 2009 OPPS Final Rule (CMS Regulation 1404-FC, posted 10/2008)

Hospital Quality Alliance
Reporting Hospital Quality Data for Annual Payment Update

Inpatient Hospital Quality Measures
(Data Submission and Hospital Compare Details for Calendar Year 2009 Discharges)

Inpatient Hospital Quality Measures	*Required Submission	Collected For:	**Hospital Compare Scheduled Release			
			Mar-09	Jun-09	Sep-09	Dec-09
MEASURES REQUIRING ABSTRACTION AND/OR ACTION BY THE HOSPITAL						
Acute Myocardial Infarction (AMI)						
AMI-1 Aspirin at Arrival ¹	11/2003	CMS/TJC	✓	✓	✓	✓
AMI-2 Aspirin Prescribed at Discharge ¹	11/2003	CMS/TJC	✓	✓	✓	✓
AMI-3 ACEI or ARB for LVSD ¹	11/2003	CMS/TJC	✓	✓	✓	✓
AMI-4 Adult Smoking Cessation Advice/Counseling ²	3Q 2006	CMS/TJC	✓	✓	✓	✓
AMI-5 Beta-Blocker Prescribed at Discharge ¹	11/2003	CMS/TJC	✓	✓	✓	✓
AMI-6 Beta-Blocker at Arrival ¹ (Collection not required for CMS RHQDAPU participation beginning 2Q 2009 discharges, Measure will retire effective 2Q 2009 and will be rejected from QIO Clinical Warehouse if submitted.)	11/2003 Retired 2Q 2009	CMS/TJC				
AMI-7 Median Time to Fibrinolysis	N/A	CMS/TJC				
AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival ²	3Q 2006	CMS/TJC	✓	✓	✓	✓
AMI-8 Median Time to Primary PCI	N/A	CMS/TJC				
AMI-8a Primary PCI Received Within 90 Minutes of Hospital Arrival ² [effective 1Q 2009 name changes to: Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)]	3Q 2006	CMS/TJC	✓	✓	✓	✓
AMI-9 Inpatient Mortality	N/A	TJC				
AMI-T1a LDL Cholesterol Assessment (OPTIONAL TEST MEASURE)	N/A	CMS				
AMI-T2 Lipid Lowering Therapy at Discharge (OPTIONAL TEST MEASURE)	N/A	CMS				
Heart Failure (HF)						
HF-1 Discharge Instructions ²	3Q 2006	CMS/TJC	✓	✓	✓	✓
HF-2 Evaluation of LVS Function ¹	11/2003	CMS/TJC	✓	✓	✓	✓
HF-3 ACEI or ARB for LVSD ¹	11/2003	CMS/TJC	✓	✓	✓	✓
HF-4 Adult Smoking Cessation Advice/Counseling ²	3Q 2006	CMS/TJC	✓	✓	✓	✓
Pneumonia (PN)						
PN-1 Oxygenation Assessment ^{1,6} (Collection not required for CMS RHQDAPU participation effective 1Q 2009, Measure will retire effective 2Q 2009 and will be rejected from QIO Clinical Warehouse if submitted)	11/2003 Retired 1Q 2009	CMS/TJC	✓	✓	✓	✓
PN-2 Pneumococcal Vaccination ¹	11/2003	CMS/TJC	✓	✓	✓	✓
PN-3a Blood Cultures Performed Within 24 Hours Prior to or 24 Hours After Hospital Arrival for Patients Who Were Transferred or Admitted to the ICU Within 24 Hours of Hospital Arrival	N/A	CMS/TJC				

Revised 4/2/2009

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Inpatient Hospital Quality Measures
(Data Submission and Hospital Compare Details for Calendar Year 2009 Discharges)

Inpatient Hospital Quality Measures	*Required Submission	Collected For:	**Hospital Compare Scheduled Release			
			Mar-09	Jun-09	Sep-09	Dec-09
Pneumonia (PN) continued						
PN-3b Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital ²	3Q 2006	CMS/TJC	✓	✓	✓	✓
PN-4 Adult Smoking Cessation Advice/Counseling ²	3Q 2006	CMS/TJC	✓	✓	✓	✓
PN-5 Antibiotic Timing (Median)	N/A	TJC	█	█	█	█
PN-5b Initial Antibiotic Received Within 4 Hours of Hospital Arrival ^{4, 6} (Submission required for RHQDAPU through 4Q 2008)	11/2003 Discontinued 1Q 2009	CMS/TJC	█	█	█	█
PN-5c Initial Antibiotic Received Within 6 Hours of Hospital Arrival ⁶ (Hospital Compare data displays PN-5c calculated from PN-5b data elements until 1Q 2009. The measure name changes to: Timing of Receipt of Initial Antibiotic Following Hospital Arrival)	1Q 2009	CMS/TJC	✓	✓	✓	✓
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patients ²	3Q 2006	CMS	✓	✓	✓	✓
PN-6a Initial Antibiotic Selection for CAP in Immunocompetent – ICU Patients	N/A	TJC	█	█	█	█
PN-6b Initial Antibiotic Selection for CAP in Immunocompetent – Non-ICU Patients	N/A	TJC	█	█	█	█
PN-7 Influenza Vaccination ² (NOTE: Reported by Flu Season ONLY)	3Q 2006	CMS/TJC	✓	✓	✓	✓
Surgical Care Improvement Project (SCIP)						
SCIP-Inf-1 Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision ²	3Q 2006	CMS/TJC	✓	✓	✓	✓
SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients ³	1Q 2007	CMS/TJC	✓	✓	✓	✓
SCIP-Inf-3 Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time ²	3Q 2006	CMS/TJC	✓	✓	✓	✓
SCIP-Inf-4 Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Blood Glucose ⁵	1Q 2008	CMS/TJC	✓	✓	✓	✓
SCIP-Inf-6 Surgery Patients with Appropriate Hair Removal ⁵	1Q 2008	CMS/TJC	✓	✓	✓	✓
SCIP-Inf-7 Colorectal Surgery Patients with Immediate Postoperative Normothermia (Data collection will be discontinued effective 4Q 2009)	N/A	CMS/TJC	█	█	█	█
SCIP-Inf-9 Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery being Day Zero	N/A	CMS/TJC	█	█	█	█
SCIP-Inf-10 Surgery Patients with Perioperative Temperature Management	N/A	CMS/TJC	█	█	█	█
SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered ³	1Q 2007	CMS/TJC	✓	✓	✓	✓
SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery ³	1Q 2007	CMS/TJC	✓	✓	✓	✓
SCIP-Card-2 Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who received a Beta-Blocker During the Perioperative Period ⁶	1Q 2009	CMS/TJC	█	█	█	✓

Inpatient Hospital Quality Measures
(Data Submission and Hospital Compare Details for Calendar Year 2009 Discharges)

Inpatient Hospital Quality Measures	*Required Submission	Collected For:	**Hospital Compare Scheduled Release			
			Mar-09	Jun-09	Sep-09	Dec-09
Children's Asthma Care (CAC)**						
CAC-1 Relievers for Inpatient Asthma	N/A	TJC	✓	✓	✓	✓
CAC-2 Systemic Corticosteroids for Inpatient Asthma	N/A	TJC	✓	✓	✓	✓
CAC-3 Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver	N/A	TJC	▨	▨	✓	✓
Pregnancy and Related Conditions (PR)						
PR-1 VBAC	N/A	TJC	▨	▨	▨	▨
PR-2 Inpatient Neonatal Mortality	N/A	TJC	▨	▨	▨	▨
PR-3 Third or Fourth Degree Laceration	N/A	TJC	▨	▨	▨	▨
Hospital Consumer Assessment of Healthcare Providers and System Survey (HCAHPS)**						
HCAHPS Hospital Consumer Assessment of Healthcare Providers and System Survey ³	3Q 2007	CMS	✓	✓	✓	✓
Cardiac Surgery Measure						
Participation in a Systematic Database for Cardiac Surgery ⁶ (Provider must enter response on QualityNet)	7/1/2009 thru 8/15/2009	CMS	▨	▨	▨	TBD
MEASURE INFORMATION OBTAINED FROM CLAIMS-BASED DATA						
30-Day Risk-Standardized Mortality Rates***						
MORT-30-AMI Acute Myocardial Infarction (AMI) 30-Day Mortality Rate ³	N/A [^]	CMS	✓	✓	✓	✓
MORT-30-HF Heart Failure (HF) 30-Day Mortality Rate ³	N/A [^]	CMS	✓	✓	✓	✓
MORT-30-PN Pneumonia (PN) 30-Day Mortality Rate ⁴	N/A [^]	CMS	✓	✓	✓	✓
30-Day Risk-Standardized Readmission Rates***						
READM-30-AMI Acute Myocardial Infarction (AMI) 30-Day Readmission Rate ⁷	N/A [^]	CMS	▨	✓	✓	✓
READM-30-HF Heart Failure (HF) 30-Day Readmission Rate ⁶	N/A [^]	CMS	▨	✓	✓	✓
READM-30-PN Pneumonia (PN) 30-Day Readmission Rate ⁷	N/A [^]	CMS	▨	✓	✓	✓
Agency for Healthcare Research and Quality (AHRQ) Measures***						
Patient Safety Indicators						
PSI 4 Death Among Surgical Patients with Treatable Serious Complications ⁶	N/A [^]	CMS	▨	▨	▨	✓
PSI 6 Iatrogenic Pneumothorax, Adult ⁶	N/A [^]	CMS	▨	▨	▨	✓
PSI 14 Postoperative Wound Dehiscence ⁶	N/A [^]	CMS	▨	▨	▨	✓
PSI 15 Accidental Puncture or Laceration ⁶	N/A [^]	CMS	▨	▨	▨	✓
PSI Complication/Patient Safety for Selected Indicators (composite) ⁶	N/A [^]	CMS	▨	▨	▨	✓

Inpatient Hospital Quality Measures
(Data Submission and Hospital Compare Details for Calendar Year 2009 Discharges)

Inpatient Hospital Quality Measures	*Required Submission	Collected For:	**Hospital Compare Scheduled Release			
			Mar-09	Jun-09	Sep-09	Dec-09
Agency for Healthcare Research and Quality (AHRQ) Measures continued***						
Inpatient Quality Indicators						
IQI 11 Abdominal Aortic Aneurysm (AAA) Mortality Rate ⁶	N/A [^]	CMS				✓
IQI 19 Hip Fracture Morality Rate ⁶	N/A [^]	CMS				✓
IQI Mortality for Selected Surgical Procedures (composite) ⁶	N/A [^]	CMS				✓
IQI Mortality for Selected Medical Conditions (composite) ⁶	N/A [^]	CMS				✓
Nursing Sensitive Measure***						
NSC-1 Death Among Surgical Patients with Treatable Serious complications ⁴	N/A [^]	CMS				TBD

LEGEND and FOOTNOTES:

All dates and quarters referenced refer to Calendar Year (CY) unless otherwise indicated (for example 1Q 2009 would represent discharges Jan-Mar 2009)

- CMS** = Centers for Medicare & Medicaid Services
- IPPS** = Inpatient Prospective Payment System
- IQI** = Inpatient Quality Indicator
- OPPS** = Outpatient Prospective Payment System
- PSI** = Patient Safety Indicator
- TJC** = The Joint Commission
- TBD** = To Be Determined
- ✓ = Displayed on 'Hospital Compare' website
- //// = Not applicable for the measure in that discharge timeframe

Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Measures
¹ Measure included in '10 measure starter set'
² Additional measure added to original '10 measure starter set' to make '21 measure expanded set' (CMS Reg. 1488-FC, posted 08/2006)
³ Measure finalized in CY 2007 OPPS Final Rule (CMS Regulation 1506-FC, posted 11/2006)
⁴ Measure finalized in FY 2008 IPPS Final Rule (CMS Regulation 1533-FC, posted 08/2007)
⁵ Measure finalized in CY 2008 OPPS Final Rule (CMS Regulation 1392-FC, posted 11/2007)
⁶ Measure finalized in CY 2009 IPPS Final Rule (CMS Regulation 1390-F, posted 8/2008)
⁷ Measure finalized in CY 2009 OPPS Final Rule (CMS Regulation 1404-FC, posted 10/2008)
[^] CMS uses enrollment data as well as Part A and Part B claims for Medicare fee-for-service patients to calculate these measures. No hospital data submission is required to calculate these measure rates.
* Discharge (D/C) Quarter Required RHQDAPU Submission Started In Accordance with the Published Final Rule (IPPS and/or OPPS)

Inpatient Hospital Quality Measures
(Data Submission and Hospital Compare Details for Calendar Year 2009 Discharges)

LEGEND and FOOTNOTES (continued):

** Clinical Process Measures, CAC Measures and HCAHPS Discharge Quarters Included in Hospital Compare Release (refreshed quarterly)
Mar-09: 3Q07, 4Q07, 1Q08 and 2Q08
Jun-09: 4Q07, 1Q08, 2Q08 and 3Q08
Sep-09: 1Q08, 2Q08, 3Q08 and 4Q08
Dec-09: 2Q08, 3Q08, 4Q08 and 1Q09
***Claims-based Measures (no data submission required) Refreshed annually on Hospital Compare
Mar-09: 3Q 2006 through 2Q 2007
Jun-09: 3Q 2005 through 2Q 2008
Sep-09: 3Q 2005 through 2Q 2008
Dec-09: 3Q 2005 through 2Q 2008 (Time span for AHRQ measures has not been determined)

This material was prepared by IFMC, the Quality Improvement Organization Support Contractor for the Hospital Reporting Program, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. 9SoW-IA-HRPQIOSC-03/09-005

Exhibit H – HITSP Background Summary

HITSP was founded in the fall of 2005 when the U.S. Department of Health and Human Services' Office of the National Coordinator for Health Information Technology (ONC) awarded multiple contracts to advance the widespread adoption of interoperable electronic health records (EHRs) within ten (10) years. The contracts targeted the creation of processes to harmonize standards, certify EHR applications, develop nationwide health information network prototypes and recommend necessary changes to standardized diverse security and privacy policies.

The American National Standards Institute (ANSI), in cooperation with strategic partners HIMSS, Booz Allen Hamilton, and Advanced Technology Institute, was selected to administer the standards harmonization initiative.

The Panel's objectives are to:

- serve and establish a cooperative partnership between the public and private sectors to achieve a widely accepted and useful set of standards that will enable and support widespread interoperability among healthcare software applications in a Nationwide Health Information Network for the United States.
- harmonize relevant standards in the healthcare industry to enable and advance interoperability of healthcare applications, and the interchange of healthcare data, to assure accurate use, access, privacy and security, both for supporting the delivery of care and public health.¹

HITSP has created a harmonization framework which defines terms, concepts and their relationship within a HITSP Interoperability Specification (IS), Component (C), Transaction (T), Transaction Package (TP), and Service Collaboration (SC). Table 01 provides definitions for HITSP constructs which are a specification based on harmonized interoperability standards.²

Construct	Definition	Example	Rules
Interoperability Specification – to meet Use Case	<ul style="list-style-type: none"> • Models business, functional, interoperability requirements to meet Use Case • Identifies technical system requirements to meet Use Case • Set context for constructs used 	<ul style="list-style-type: none"> • HITSP EHR Interoperability Specification 	<ul style="list-style-type: none"> • Identifies technical actors and actions • May include any other HITSP construct -components, transactions or transaction packages • Expresses constraints on HITSP constructs used
Transaction Packages	Defines how HITSP constructs are used to support a stand-alone information interchange within a defined context between two or more systems	<ul style="list-style-type: none"> • Record Locator Service • Entity Identification Service • Manage Sharing of Documents 	<ul style="list-style-type: none"> • Thin context and interoperability requirements that are testable • Addresses like technical actors, context, and content • May use and constrain two or more transactions and/or one or more composite standards • In special circumstances, may use and constrain

			infrastructure or security component constructs
Transaction	Logical grouping of actions, including necessary content and context, that must all succeed or fail as a group	<ul style="list-style-type: none"> • Query lab result • Send lab result 	<ul style="list-style-type: none"> • Fulfills actions between systems needed to meet one or more interoperability requirements • Testable • May use components or composite standards • Express constraints on composite standards or components used
Components	An atomic construct used to support an information interchange or to meet an infrastructure requirement (e.g., security, logging/audit)	<ul style="list-style-type: none"> • Lab result message • Lab result context 	<ul style="list-style-type: none"> • Typically will use one "primary" standard and may have other "secondary" standards • Expresses constraints on base or composite standards used

Beginning in April, 2009, HITSP took its existing work products – 13 Interoperability Standards (IS) and 60 related constructs, and mapped the EHR information exchange related work products to ARRA requirements. On July 8, 2009 HITSP approved HITSP/IS107 – EHR Centric Interoperability Specification. This specification contains 26 Capabilities (CAP) that support the workflow, information content, infrastructure, and security and privacy requirements laid out in the ARRA legislation.

HITSP has then taken the Capabilities, and Mapped them to the Interoperability Specifications. The following IS Table 5-1 from the HITSP EHR-Centric Interoperability Specification.

Table 5-1 HITSP Capabilities Mapped to Interoperability Specifications

HITSP Capabilities																			Supporting Components of the HITSP Interoperability Specifications IHE profiles shown when relevant to the specified HITSP component								
CAP 140	CAP 141	CAP 142	CAP 143	CAP 117	CAP 118	CAP 119	CAP 120	CAP 121	CAP 122	CAP 123	CAP 124	CAP 125	CAP 126	CAP 127	CAP 128	CAP 129	CAP 130	CAP 131		CAP 132	CAP 133	CAP 135	CAP 136	CAP 137	CAP 138	CAP 139	
Exchange Administrative Benefits/Eligibility transactions specification	Exchange Administrative Referral/Authorization Transactions Specifications	Retrieve Communications Recipient	Consumer Preferences and Consent Management	Communicate Ambulatory and Long Term Care Prescription Specification	Communicate Hospital Prescription Specification	Communicate Structured Document Specification	Communicate Unstructured Document Specification	Communicate Clinical Referral Request Specification	Retrieve medical Knowledge Specifications	Retrieve existing data Specifications	Establish Secure web access Specifications	Retrieve Genomic Decision Support Specifications	Communicate Lab Results Message Specifications	Communication of Lab Results Document Specifications	Communicate Imaging Information Specifications	Communicate Quality Measure Data Specifications	Communicate Quality Measure Specification Specifications	Immunization Registry update Specifications	Immunization Registry Query Specifications	Communication of Immunization Summary Specifications	Retrieve Pre-populated Form for Data Capture Specifications	Emergency Alerting Specifications	Send and Receive clinical data message Specifications	Assign pseudo-identity Specifications	Communicate Resource Utilization Specifications		
ADMINISTRATIVE and FINANCIAL				Medication Management	Exchange of Clinical Data				Exchange of Laboratory and Imaging Data				Quality Management	Immunization		Case Reporting and Bio-surveillance		Emergency	Original AHIC Use Cases								
				CLINICAL OPERATIONS (Care Delivery, Emergency Responder and Consumer Empowerment)								CLINICAL QUALITY AND PUBLIC HEALTH							Provider Perspective								
			•																								IS 01 - Electronic Health Record (EHR) Laboratory Results Reporting
			•																								IS 04 - Emergency Responder Electronic Health Record (ER-EHR)
			•																								IS 08 - Personalized Healthcare
			•																								IS 09 - Consultations and Transfers of Care
				Population Perspective																							
			•																								IS 02 - Biosurveillance
			•																								IS 06 - Quality
			•																								IS 10 - Immunizations and Response Management
			•																								IS 11 - Public Health Case Reporting
				Consumer Perspective																							
			•																								IS 03 - Consumer Empowerment
			•																								IS 05 - Consumer Empowerment and Access to Clinical Information via
			•																								IS 07 - Medication Management
			•																								IS 12 - Patient – Provider Secure Messaging
			•																								IS 77 - Remote Monitoring

DRAFT

Exhibit I – CAP119

3.4 HITSP/CAP119 – COMMUNICATE STRUCTURED DOCUMENT SPECIFICATION

This Capability addresses interoperability requirements that support the communication of structured health data related to a patient in a context set by the source of the document who is attesting to its content. Several document content subsets, structured according to the HL7 CDA standard, are supported by this Capability. The following are examples of the type of structured data that may be used:

Continuity of Care Document (CCD)

Emergency Department Encounter Summary

Discharge Summary (In-patient encounter and/or episodes of care)

Referral Summary Ambulatory encounter and/or episodes of care

Consultation Notes

History and Physical

Personal Health Device Monitoring Document

Healthcare Associated Infection (HAI) Report Document

Document creators shall support a number of the HITSP specified coded terminologies as defined by specific content subsets specified in this Capability.

3.4.1

DESIGN SPECIFICATION

3.4.1.1

INTERACTING SYSTEMS

Table 3-15

Interacting Systems Interacting Systems
Electronic Health Record (EHR) Systems
Personal Health Record (PHR) Systems
Public Health Information System
Health Information Exchange (HIE) / Regional Health Information Organizations (RHIO)
Laboratory Information Systems
Emergency Communications System
Immunization Information System
Clinical Decision Support System
Quality Measure Processing Entity

3.4.1.3 LIST OF CONSTRUCTS

Table 3-17

List of Constructs Construct	Description
HITSP/C28 – Emergency Care Summary Document Using IHE Emergency Department Encounter Summary (EDES)	The HITSP Emergency Care Summary Document Using IHE Emergency Department Encounter Summary (EDES) Component is the collection of data from multiple sources (such as physicians, nurses, technologists, etc.) recording the assessments and care delivered by the ED team in response to an ED visit. It is a summary of the patient's current health status and care tendered in the ED between arrival and ED departure. This Component specifies the use of the IHE Emergency Department Encounter Summary (EDES), Technical Framework Supplement, Volume I, Revision 3.0, 2007-2008
HITSP/C32 – Summary Documents Using HL7 Continuity of Care Document (CCD)	The HITSP Summary Documents Using HL7 Continuity of Care Document (CCD) Component describes the document content summarizing a consumer's medical status for the purpose of information exchange. The content may include administrative (e.g., registration, demographics, insurance, etc.) and clinical (problem list, medication list, allergies, test results, etc) information. This Component defines content in order to enable interoperability between participating systems such as Personal Health Record Systems (PHRs), Electronic Health Record Systems (EHRs), Practice Management Applications and others
HITSP/C39 – Encounter Message	The HITSP Encounter Message Component supports the process of sending patient encounter data (excluding laboratory, radiology) from a Biosurveillance Message Sender to a Biosurveillance Message Receiver
HITSP/C48 – Encounter Document Using IHE Medical Summary (XDS-MS)	The HITSP Encounter Document Using IHE Medical Summary (XDS-MS) Component supports the process of sending patient encounter data (excluding laboratory and radiology) in a document sharing functional flow scenario. Patient encounter data are captured as part of the normal process of care performed by healthcare providers, such as hospitals, emergency departments and outpatient clinics
HITSP/C74 – Remote Monitoring Observation Document	The HITSP Remote Monitoring Observation Document Component describes the document content to convey medical information collected by remote monitoring management systems from monitoring devices and/or device intermediaries for the purpose of information exchange. The content may include administrative (e.g., registration, demographics, insurance, etc.) and clinical (results, vital signs, etc) information. This specification defines content in order to promote interoperability between participating systems. Such systems may include Remote Monitoring Management Systems, Personal Health Record Systems (PHRs), Electronic Health Record Systems (EHRs), Health Information Exchange infrastructure services and other persons and systems as identified and permitted
HITSP/C75 – Healthcare Associated Infection (HAI) Report	The HITSP Healthcare Associated Infection (HAI) Report Component specifies a standard for electronic submission of Healthcare Associated Infection (HAI) Reports to the National Healthcare Safety Network (NHSN) of the Centers for Disease Control and Prevention (CDC). HITSP has adopted the HL7 Implementation Guide for CDA Release 2: NHSN Healthcare Associated Infection (HAI) Reports, Release 1 for this construct
HITSP/C78 – Immunization Document	The HITSP Immunization Document Component defines the immunization data content to be exchanged between healthcare entities such as immunization information systems, electronic medical records systems, personal healthcare record systems and other stakeholders. It is based upon the IHE Patient Care Coordination (PCC) Technical Framework Supplement 2008-2009, Immunization Content (IC), Trial Implementation Version 1.0
HITSP/C80 – Clinical Document and Message Terminology	The HITSP Clinical Document and Message Terminology Component defines the vocabularies and terminologies utilized by HITSP specifications for Clinical Documents and Messages used to support the interoperable transmission of information
HITSP/C83 – CDA Content Modules	The HITSP CDA Content Modules Component defines the content modules for document based HITSP constructs utilizing clinical information. These Content modules are based on IHE PCC Technical Framework Volume II, Release 4. That technical framework contains specifications for document sections that are consistent with all implementation guides for clinical documents currently selected for HITSP constructs
HITSP/C84 – Consult and History & Physical Note	The HITSP Consult and History & Physical Note Component supports two types of commonly used clinical notes, a consult note, and a history and physical note. It is intended for use to support the exchange of information from a consulting provider to a referring provider; and may also be used to provide background information from a referring provider to a consulting provider (e.g., prior reports)
HITSP/SC112 – Healthcare Document Management	The HITSP Healthcare Document Management Service Collaboration provides the ability to share healthcare documents using a set of topologies, such as Media, e-Mail, Point-to-Point, Shared within a Health Information Exchange, and Shared within a larger community (made up of potentially diverse Health Information Exchanges)

13 Optionality = "R" for Required, "R2" for Required if known, "O" for Optional, or "C" for Conditional. If applicable, conditional footnotes are further described below.

3.4.1.4 SPECIFIED INTERFACES

Table 3-18 HITSP/CAP119 – Communicate Structured Document Specified Interfaces

Interface (Initiating or Responding)	Interface number	Interface Condition	T/TP/SC or Content	T/TP/SC/Content Optionality ¹³
Content Creator	1	R	Creator-Registration Subset (see Section 3.4.1.5.1)(HITSP/C32)	CAP119-[201]
			Creator-Registration-Coded Subset (see Section 3.4.1.5.2)(HITSP/C32)	CAP119-[201]
			Creator-Medication and Immunization History Subset (see Section 3.4.1.5.3)(HITSP/C32)	CAP119-[201]
			Creator-Medication and Immunization History – Coded Subset (see Section 3.4.1.5.4)(HITSP/C32)	CAP119-[201]
			Creator-Conditions and Allergy Subset (see Section 3.4.1.5.5)(HITSP/C32)	CAP119-[201]
			Creator-Conditions and Allergy -Coded Subset (see Section 3.4.1.5.6)(HITSP/C32)	CAP119-[201]
			Creator-Laboratory Section Subset (see Section 3.4.1.5.7)(HITSP/C32)	CAP119-[201]
			Creator-Laboratory Section -Coded Subset (see Section 3.4.1.5.8)(HITSP/C32)	CAP119-[201]
			Creator-Medication and Allergies Subset (See Section 3.4.1.5.9) (HITSP/C32)	CAP119-[201]
			Encounter Document Using IHE Medical Summary (XDS-MS) Component(HITSP/C48)	CAP119 -201]
			Structured Family History Creator-Structured Family History subset (see Section 3.4.1.5.10)(HITSP/C48)	CAP119-[201]
			Emergency Department Encounter(HITSP/C28)	CAP119-[201], [202]
			Consult and History & Physical Note(HITSP/C84)	CAP119-[201]
			Structured Family History – Content Creator (See Section 3.4.1.5.11)(HITSP/C84)	CAP119-[201]
			Remote Monitoring Observation Document(HITSP/C74)	CAP119-[201]
			Adverse Event Reports: CDC – Healthcare Associated Infection Reporting (HITSP/C75)	CAP119-[201]
			Clinical Document and Message Terminology(HITSP/C80)	R
			CDA Content Modules (HITSP/C83)	R
Content Consumer	2	R	Consumer-Document Display)(HITSP/C32)	R
			Consumer-Document Import (HITSP/C32)	CAP119-[203]
			Consumer-Registration Discrete Data Import (HITSP/C32)	CAP119-[203]
			Consumer-Medication and Immunization History Discrete Data Import Subset (see Section 3.4.1.5.12)(HITSP/C32)	O
			Consumer-Conditions and Allergy Discrete Data Import Subset (see Section 3.4.1.5.13)(HITSP/C32)	O
			Consumer-Medication and Allergies Information Import Subset (See Section	O

			3.4.1.5.14)(HITSP/C32)	
			Structured Family History Consumer-Docum Import Subset (see Section3.4.1.5.15)(HITSP/C32)	O
			Structured Family History Consumer-Docum Discrete Data Import (see Section 3.4.1.5.16)(HITSP/C32)	O
			Consumer-Docum Display (HITSP/C28)	R
			Consumer-Docum Import (HITSP/C28)	CAP119-[203]
			Consumer-Docum Discrete Data Import HITSP/C28)	CAP119-[203]
			Consumer-Docum Display (HITSP/C48)	R
			Consumer-Docum Import (HITSP/C48)	CAP119-[203]
			Consumer-Docum Discrete Data Import(HITSP/C48)	CAP119-[203]
			Structured Family History Consumer-Docum Import (see Section 3.4.1.5.17)(HITSP/C48)	O
			Structured Family History Consumer-Docum Discrete Data Import Subset (See Section 3.4.1.5.18)(HITSP/C48)	O
			Consumer-Docum Display(HITSP/C84)	R
			Consumer-Docum Import(HITSP/C84)	CAP119-[203]
			Consumer-Docum Discrete Data Import(HITSP/C84)	CAP119-[203]
			Structured Family History Consumer-Docum Import Subset (see Section 3.4.1.5.19)(HITSP/C84)	O
			Structured Family History Consumer-Docum Discrete Data Import Subset (see Section 3.4.1.5.20)(HITSP/C84)	O
			Consumer-Docum Display (HITSP/C74)	R
			Consumer-Docum Import (HITSP/C74)	CAP119-[203]
			Consumer-Docum Discrete Data Import (HITSP/C74)	CAP119-[203]
			Consumer-Docum Display (HITSP/C78)	R
			Consumer-Docum Import (HITSP/C78)	CAP119-[203]
			Consumer-Docum Discrete Data Import (HITSP/C78)	CAP119-[203]
			Clinical Document and Message Terminology(HITSP/C80)	R
			CDA Content Modules(IHTSP/C83)	R
Send Documents	3	CAP119- [101], [102]	Healthcare Document Management (HITSP/SC112)	R
Receive Documents	4	CAP119- [101]	Healthcare Document Management (HITSP/SC112)	R

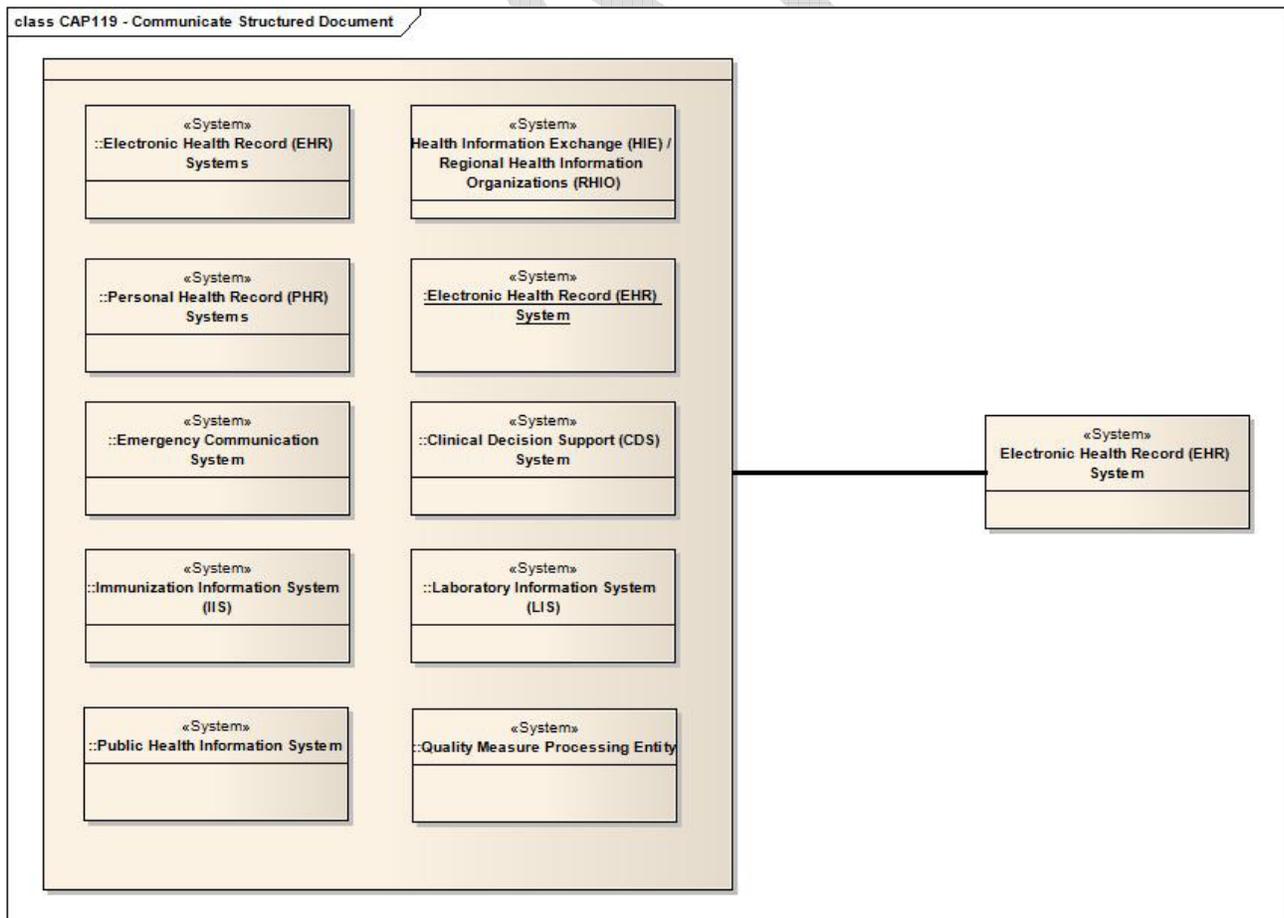
Table 3-19 Interface Conditions and T/TP/SC/Content Optionality

Condition Code	Condition Description
CAP119-[101]	An implementation shall choose amongst one of the interfaces defined in HITSP/SC112 Healthcare Document Management. This choice is dependent on the topology chosen (See Table 3-1 Information Exchange Topologies Mapped to Capabilities above), the physical limitations, policies and processes of the implementation
CAP119-[102]	The EHR System may optionally choose to implement a Document Repository or use an external repository for the Send Documents through Share option of HITSP/SC112 Healthcare Document Management
CAP119-[201]	Shall support either at least one of the subsets of the HITSP/C32 – Summary Documents Using HL7 Continuity of Care Document (CCD), HITSP/C37 – Lab Report Document, the

	entire document or at least one of the subsets of HITSP/C48 – Encounter Document Using IHE Medical Summary (XDS-MS), HITSP/C28 – Emergency Department Encounter, the entire document or at least one of the subsets of HITSP/C84 – Consult and History & Physical Note, HITSP/C74 – Remote Monitoring Observation Document, HITSP/C75 – Adverse Event Reports: CDC – Healthcare Associated Infection Reporting Document, or any combination of the these constructs
CAP119-[202]	Shall be supported if the EHR is used by an emergency department
CAP119-[203]	<p>The Content Consumer should minimally Display the content received in the specified CDA document (i.e. HITSP/C32, HITSP/C28, HITSP/C48, HITSP/C74, HITSP/C78, and HITSP/C84). Optionally, the Content Consumer may support one or both of the following functions:</p> <p style="padding-left: 40px;">Consumer-Document Import [Requires the Content Consumer to have the ability to import the CDA document into the patient record as a whole and display it as requested]</p> <p style="padding-left: 40px;">Consumer-Discrete Data Import [Requires the Content Consumer to have the ability to import the discrete data from one or more of the data section entries in a structured form into the patient record. Coded values shall be maintained.]</p> <p>The specific data sections which have been described in HITSP documents which can be optionally supported have been identified as Discrete Data Import subsets.</p>

The following diagram shows a visual overview of the Capability using UML notation. The visual overview outlines how the interacting systems work together as part of implementing the Capability. The thick arrow in the middle of the diagram outlines how sets of systems can interact together, and represent the information exchange requirement (IER) inherent to the Capability. An IER is not explicitly noted as part of this diagram.

Figure 3-4 HITSP/CAP119 – Communicate Structured Document Visual Overview



3.4.1.5 CAPABILITY OPTIONS

Note that subsets of the data content can be sent as appropriate for the application; but the system must be able to address the entire data content. Note that transport options can be addressed.

3.4.1.5.1 HITSP/C32 "Creator-Registration Subset"

This subset impacts the content of the HITSP/C32 Summary Document Using HL7 Continuity of Care Document (CCD) document produced by a Content Creator Interface. It requires the Content Creator to have the **ability to create the content** of the following content modules for the purpose of exchange, with variants as specified in the HITSP/C32 construct:

¹⁴ Optionality = "R" for Required, "R2" for Required if known, "O" for Optional, or "C" for Conditional. If applicable, conditional footnotes are further described below.

¹⁵ Optionality = "R" for Required, "R2" for Required if known, "O" for Optional, or "C" for Conditional. If applicable, conditional footnotes are further described below.

Table 3-20 Creator Registration Subset Content Modules

Content Modules	Optionality ¹⁴
Advance Directive	R2
Comments	R2
Healthcare Provider	R2
Information Source	R2
Insurance Provider	R2
Language Spoken	R2
Person Information	R
Pregnancy	R2
Support	R2

¹⁴ Optionality = "R" for Required, "R2" for Required if known, "O" for Optional, or "C" for Conditional. If applicable, conditional footnotes are further described below.

¹⁵ Optionality = "R" for Required, "R2" for Required if known, "O" for Optional, or "C" for Conditional. If applicable, conditional footnotes are further described below.

Additional HITSP/C32 content modules may be present, but are not required in this subset. Within the context of this subset, the content consumer is not required to recognize or process such "additional" content modules.

The Support content module includes emergency contact information when available.

The type of payer and type of payer entries contain the concepts but without the HITSP/C32 specified code set.

3.4.1.5.2 HITSP/C32 "Creator-Registration-Coded Subset"

This subset is identical to the Creator-Registration Subset but requires the creation of type of payer and type of payer entries with the HITSP/C32 specified code set.

3.4.1.5.3

HITSP/C32 "Creator-Medication and Immunization History Subset"

This subset impacts the content of the HITSP/C32 Summary Document Using HL7 Continuity of Care Document (CCD) document produced by a Content Creator Interface. It requires the Content Creator to have the ability to create the content of the following content module for the purpose of exchange, with variants as specified in the HITSP/C32 construct:

Table 3-21 Creator Medication and Immunization History Subset Content Modules

Content Modules	Optionality¹⁵
Comments	R2
Healthcare Provider	R2
Immunization	R2
Information Source	R2
Medications – Prescription and Non-Prescription	R2
Person Information	R

Additional HITSP/C32 content modules may be present, but are not required in this subset. Within the context of this subset, the content consumer is not required to recognize or process such "additional" content modules.

The Medication entry may contain the concepts but without an associated code.

3.4.1.5.4

HITSP/C32 "Creator-Medication and Immunization History-Coded Subset"

This subset is identical to the Creator-Medication Subset but requires the creation of medication entries with the HITSP/C32 specified code sets.

3.4.1.5.5

HITSP/C32 "Creator-Conditions and Allergy Subset"

This subset impacts the content of the HITSP/C32 Summary Documents Using HL7 Continuity of Care Document (CCD) document produced by a Content Creator Interface. It requires the Content Creator to have the ability to create the content for the purpose of exchange as specified in the HITSP/C32 construct:

Table 3-22 Creator Conditions and Allergy Subset Content Modules

Content Modules	Optionality¹⁶
Allergies and Drug Sensitivity	R2
Comments	R2
Condition	R2
Healthcare Provider	R2
Information Source	R2
Person Information	R

Additional HITSP/C32 content modules may be present, but are not required in this subset. Within the context of this subset, the content consumer is not required to recognize or process such "additional" content modules.

The Condition and Allergy entries contain the concepts but without the HITSP/C32 specified code set.

3.4.1.5.6
 HITSP/C32 “Creator-Conditions and Allergy-Coded Subset”

This subset is identical to the Creator-Registration Subset but requires the creation of conditions and allergies entries with the HITSP/C32 specified code set.

3.4.1.5.7
 HITSP/C32 “Creator-Laboratory Section Subset”

This subset impacts the content of the HITSP/C32 Summary Documents Using HL7 Continuity of Care Document (CCD) document produced by a Content Creator Interface. It requires the Content Creator to have the ability to create the content for the purpose of exchange as specified in the HITSP/C32 construct:

¹⁶ Optionality = “R” for Required, “R2” for Required if known, “O” for Optional, or “C” for Conditional. If applicable, conditional footnotes are further described below.

¹⁷ Optionality = “R” for Required, “R2” for Required if known, “O” for Optional, or “C” for Conditional. If applicable, conditional footnotes are further described below

Table 3-23 Creator Laboratory Subset Content Modules

Content Modules	Optionality ¹⁷
Comments	R2
Healthcare Provider	R2
Information Source	R2
Person Information	R
Result	R2

Additional HITSP/C32 content modules may be present, but are not required in this subset. Within the context of this subset, the content consumer is not required to recognize or process such "additional" content modules.

The Result entries contain the concepts but without the HITSP/C32 specified code set.

3.4.1.5.8
 HITSP/C32 “Creator-Laboratory Section-Coded Subset”

This subset is identical to the Creator-Laboratory Section Subset but requires the creation of laboratory results entries with the HITSP/C32 specified code set.

3.4.1.5.9
 HITSP/C32 “Creator-Medication and Allergies Information Coded Subset”

This subset impacts the content of the HITSP/C32 – Summary Document Using HL7 Continuity of Care Document (CCD) Component produced by a Content Creator Interface. It requires the Content Creator to have the ability to create the content of the following content modules with the HITSP specified code set for the purpose of exchange, with variants as specified in the HITSP/C32 construct:

Table 3-24 Creator Medication and Allergies Information Subset Content Modules

Content Modules	Optionality ¹⁸
Person Information	R
Medications – Prescription and Non-	R

Prescription	
Allergies and Drug Sensitivity	R
Healthcare Provider	R2
Insurance Provider	R2
Information Source	R2
Conditions	R2
Comments	R2

Additional HITSP/C32 content modules may be present, but are not required in this subset. Within the context of this subset, the content consumer is not required to recognize or process such "additional" content modules.

3.4.1.5.10

HITSP/C48 "Structured Family History Creator-Structured Family History Subset"

These documents **shall** contain data sections conforming to the requirements specified for the following CDA content modules in HITSP/C83 CDA Content Modules:

Table 3-25 Structured Family History Creator-Structured Family History Subset Content Modules

Content Modules	Optionality ¹⁹
Family History	R
Allergies and Adverse Reactions	R
Active Problems	R
History of Past Illness	R
Diagnostic Results	R

¹⁸ Optionality = "R" for Required, "R2" for Required if known, "O" for Optional, or "C" for Conditional. If applicable, conditional footnotes are further described below.

¹⁹ Optionality = "R" for Required, "R2" for Required if known, "O" for Optional, or "C" for Conditional. If applicable, conditional footnotes are further described below.

3.4.1.5.11 HITSP/C84 "Structured Family History – Content Creator Subset"

These documents **shall** contain data sections conforming to the requirements specified for the following CDA content modules in HITSP/C83 CDA Content Modules:

Table 3-26 Structured Family History – Content Creator Subset Content Modules

Content Modules	Optionality ²⁰
Family History	R
Allergies and Adverse Reactions	R
Active Problems	R
History of Past Illness	R
Diagnostic Results	R

3.4.1.5.12 HITSP/C32 "Consumer-Medication and Immunization History Discrete Data Import Subset"

This subset impacts the import of the HITSP/C32 Summary Documents Using HL7 Continuity of Care Document (CCD) document processed by a Content Consumer Interface. It requires the Document Consumer to have the ability to import the discrete data from one or more of the medication and immunization history entries in a structured form into the patient record. Coded values shall be maintained.

3.4.1.5.13

HITSP/C32 “Consumer-Conditions and Allergy Discrete Data Import Subset”

This subset impacts the import of the HITSP/C32 Summary Documents using HL7 Continuity of Care Document (CCD) document processed by a Content Consumer Interface. It requires the Document Consumer to have the ability to import the discrete data from one or more of the conditions and allergy entries in a structured form into the patient record. Coded values shall be maintained.

3.4.1.5.14

HITSP/C32 “Consumer-Medication and Allergies Import Subset

This subset impacts the import of Documents processed by a Content Consumer Interface. It requires the Document Consumer to have the ability to import into the patient record the medication and allergies modules of HITSP/C32 as a whole and display it as requested.

3.4.1.5.15

HITSP/C32 “Structured Family History Consumer-Documents Import Subset”

This subset impacts the import of Documents processed by a Content Consumer Interface. It requires the Document Consumer to have the ability to import into patient record the HITSP/C32 containing structured family history as a whole and display it as requested.

3.4.1.5.16

HITSP/C32 “Structured Family History Consumer-Documents Discrete Data Import Subset”

This subset impacts the import of the HITSP/C32 Summary Documents Using HL7 Continuity of Care Document (CCD) document processed by a Content Consumer Interface. It requires the Document Consumer to have the ability to import the discrete data from one or more of the structured family history entries in a structured form into the patient record. Coded values shall be maintained.

3.4.1.5.17 HITSP/C48 “Structured Family History Consumer-Documents Import Subset”

This subset impacts the import of Documents processed by a Content Consumer Interface. It requires the Document Consumer to have the ability to import into patient record the HITSP/C48 Encounter Document Using IHE Medical Summary (XDS-MS) containing structured family history as a whole and display it as requested.

3.4.1.5.18

HITSP/C48 “Structured Family History Consumer-Documents Discrete Data Import Subset”

This subset impacts the import of the HITSP/C48 – Encounter Document Using IHE Medical Summary (XDS-MS) document processed by a Content Consumer Interface. It requires the Document Consumer to have the ability to import the discrete data from one or more of the structured family history entries in a structured form into the patient record. Coded values shall be maintained.

3.4.1.5.19

HITSP/C84 “Structured Family History Consumer-Documents Import Subset”

This subset impacts the import of Documents processed by a Content Consumer Interface. It requires the Document Consumer to have the ability to import into patient record the HITSP/C84 Consult and History & Physical Note containing structured family history as a whole and display it as requested.

3.4.1.5.20

HITSP/C84 “Structured Family History Consumer-Document Discrete Data Import Subset”

This subset impacts the import of the HITSP/C84 Consult and History & Physical Note document processed by a Content Consumer Interface. It requires the Document Consumer to have the ability to import the discrete data from one or more of the structured family history entries in a structured form into the patient record. Coded values shall be maintained.

Document Consumer only to have the ability to display HITSP/C74 Remote Monitoring Observation Document, as requested (it may not be able to locally import it in the patient record).

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Exhibit J – Value Set Definitions

Value Set	Link	Status	
		Epic	Siemens
Gender Value Set	See Table 2-38		
Marital Status Value Set	See Table 2-41		
Contact Value Set	See Table 2-45		
Diagnosis Type Value Set	See Table 2-62		
Social History Type Set	See Table 2-57		
Problem Type Value Set	See Table 2-60		
Diagnosis Type Value Set	See Table 2-62		
Problem Severity Value Set	See Table 2-67		
Vital Sign Result Value Set	See Table 2-103		
Provider Role Value Set	See Table 2-107		
Provider Type Value Set	See Table 2-109		
Patient Class Value Set	See Table 2-115		
Advance Directive Type	See Table 2-117		
Document Class Value Set	See Table 2-126		
Practice Setting Value Set	See Table 2-129		

Value Set Definitions:

Table 2-28 Code Systems from National Uniform Billing Committee¹

Code System Source	National Uniform Billing Committee (NUBC)
Code System Name	Uniform Bill (UB-04) Current UB Data Specification Manual
Code System URL	http://www.nubc.org
Code System Version	2004

Table 2-38 Administrative Gender Value Set Definition¹

Concept Code	Concept Name	Definition
F	Female	Female
M	Male	Male
UN	Undifferentiated	The gender of a person could not be uniquely defined as male or female, such as hermaphrodite

Table 2-41 Marital Status Value Set Definition¹

Concept Code	Concept Name	Definition
A	Annulled	Marriage contract has been declared null and to not have existed
D	Divorced	Marriage contract has been declared dissolved and inactive
I	Interlocutory	Subject to an Interlocutory Decree
L	Legally Separated	Legally separated
M	Married	A current marriage contract is active
P	Polygamous	More than 1 current spouse
S	Never Married	No marriage contract has ever been entered
T	Domestic partner	Person declares that a domestic partner relationship exists
W	Widowed	The spouse has died

Table 2-45 Contact Type Value Set Definition¹

Concept Code	Concept Name	Definition
AGNT	Agent	An entity that acts or is authorized to act on behalf of another entity (scoper)
CAREGIVER	Caregiver	A person responsible for the primary care of a patient at home
ECON	Emergency Contact	An entity to be contacted in the event of an emergency
GUARD	Guardian	Guardian of a ward
NOK	Next of kin	An individual designated for notification as the next of kin for a given entity
PRS	Personal	Links two people in a personal relationship

Table 2-57 Social History Type Set Definition¹

Concept Code	Concept Name (SNOMED Fully Specified Name)	Definition	Usage Note
229819007	Tobacco use and exposure (observable entity)	Not available	Smoking
256235009	Exercise (observable entity)	Not available	Exercise
160573003	Alcohol intake (observable entity)	Not available	ETOH (Alcohol) Use
364393001	Nutritional observable (observable entity)	Not available	Diet
364703007	Employment detail (observable entity)	Not available	Employment
425400000	Toxic exposure status (observable entity)	Not available	Toxic Exposure
363908000	Details of drug misuse behavior (observable entity)	Not available	Drug Use
228272008	Health-related behavior (observable entity)	Not available	Other Social History

Table 2-60 Problem Type Value Set Definition¹

Concept Code	Concept Name (SNOMED Fully Specified Name)	Definition	Usage Note
404684003	Clinical finding (finding)	Not Available	Finding
418799008	Finding reported by subject or history provider (finding)	Not Available	Symptom
55607006	Problem (finding)	Not Available	Problem
409586006	Complaint (finding)	Not Available	Complaint

64572001	Disease (disorder)	Not Available	Condition
282291009	Diagnosis interpretation (observable entity)	Not Available	Diagnosis
248536006	Finding of functional performance and activity (finding)	Not Available	Functional limitation

Table 2-62 Diagnosis Type Value Set Definition¹

Concept Code	Concept Name	Definition
A	Admitting	Not Available
F	Final	Not Available
W	Working	Not Available

Table 2-67 Problem Severity Value Set Definition¹

Concept Code	Concept Name (SNOMED Fully Specified Name)	Definition	Usage Note
255604002	Mild (qualifier value)	Not Available	mild
371923003	Mild to moderate (qualifier value)	Not Available	mild to moderate
6736007	Moderate (severity modifier) (qualifier value)	Not Available	moderate
371924009	Moderate to severe (qualifier value)	Not Available	moderate to severe
24484000	Severe (severity modifier) (qualifier value)	Not Available	severe
399166001	Fatal (qualifier value)	Not Available	fatal

Table 2-88 No Immunization Reason Value Set Definition¹

Concept Code	Concept Name	Definition
IMMUNE	Immunity	Testing has shown that the patient already has immunity to the agent targeted by the immunization
MEDPREC	medical precaution	The patient currently has a medical condition for which the vaccine is contraindicated or for which precaution is warranted
OSTOCK	Out of stock	There was no supply of the product on hand to perform the service
PATOBJ	patient objection	The patient or their guardian objects to receiving the vaccine
PHILISOP	philosophical objection	The patient or their guardian objects to receiving the vaccine because of philosophical beliefs
RELIG	religious objection	The patient or their guardian objects to receiving the vaccine on religious grounds
VACEFF	vaccine efficacy concerns	The intended vaccine has expired or is otherwise believed to no longer be effective Example: Due to temperature exposure
VACSAF	vaccine safety concerns	The patient or their guardian objects to receiving the vaccine because of concerns over its safety

Table 2-90 Immunization Information Source Value Set Definition¹

Concept Code	Concept Name	Definition
00	New immunization record	Not Available
01	Historical information - source unspecified	Not Available
02	Historical information - from other provider	Not Available

03	Historical information - from parent's written record	Not Available
04	Historical information - from parent's recall	Not Available
05	Historical information - from other registry	Not Available
06	Historical information - from birth certificate	Not Available
07	Historical information - from school record	Not Available
08	Historical information - from public agency	Not Available

Table 2-97 V3 Result Normalcy Value Set Definition¹

Concept Code	Concept Name	Definition
B	better	Better (of severity or nominal observations)
D	decreased	Significant change down (quantitative observations, does not imply B or W)
U	increased	Significant change up (quantitative observations, does not imply B or W)
W	worse	Worse (of severity or nominal observations)
<	low off scale	Below absolute low-off instrument scale. This is statement depending on the instrument, logically does not imply LL or L (e.g., if the instrument is inadequate). If an off-scale value is also low or critically low one must also report L and LL respectively
>	high off scale	Above absolute high-off instrument scale. This is statement depending on the instrument, logically does not imply LL or L (e.g., if the instrument is inadequate). If an off-scale value is also high or critically high one must also report H and HH respectively
A	Abnormal	Abnormal (for nominal observations, all service types)
AA	Abnormal alert	Abnormal alert (for nominal observations and all service types)
HH	High alert	Above upper alert threshold (for quantitative observations)
LL	Low alert	Below lower alert threshold (for quantitative observations)
H	High	Above high normal (for quantitative observations)
L	Low	Below low normal (for quantitative observations)
N	Normal	Normal (for all service types)
I	Intermediate	Intermediate
MS	moderately susceptible	Moderately susceptible
R	resistant	Resistant
S	susceptible	Susceptible
VS	very susceptible	Very susceptible
HX	above high threshold	The numeric observation/test result is interpreted as being above the high threshold value for a particular protocol within which the result is being reported Example: An ALT (SGOT) result above a protocol-defined threshold value of 2.5 times the upper limit of normal based on the subject's sex and age
LX	below low threshold	The numeric observation/test result is interpreted as being below the low threshold value for a particular protocol within which the result is being reported Example: A Total White Blood Cell Count falling below a protocol-defined threshold value of 3000/mm ³

Table 2-99 V2 Result Status Value Set Definition¹

Concept Code	Concept Name	Definition
A	Some, but not all, results available	Not Available
C	Correction to results	Not Available
F	Final results; results stored and verified. Can only be changed with a corrected result	Not Available
I	No results available; specimen received, procedure incomplete	Not Available
O	Order received; specimen not yet received	Not Available
P	Preliminary: A verified early result is available, final results not yet obtained	Not Available
R	Results stored; not yet verified	Not Available
S	No results available; procedure scheduled, but not done	Not Available
X	No results available; Order canceled	Not Available
Y	No order on record for this test. (Used only on queries)	Not Available
Z	No record of this patient. (Used only on queries)	Not Available

Table 2-101 V3 Result Status Value Set Definition¹

Concept Code	Concept Name	Definition
completed	Completed	An Act that has terminated normally after all of its constituents have been performed
aborted	Aborted	The Act has been terminated prior to the originally intended completion
active	Active	The Act can be performed or is being performed
cancelled	Cancelled	The Act has been abandoned before activation
held	Held	An Act that is still in the preparatory stages has been put aside. No action can occur until the Act is released
new	New	An Act that is in the preparatory stages and may not yet be acted upon
suspended	Suspended	An Act that has been activated (actions could or have been performed against it), but has been temporarily disabled. No further action should be taken against it until it is released

Table 2-103 Vital Sign Result Value Set Definition¹

Concept Code	Concept Name	Definition	Usage Note	Code System Name
9279-1	Respiratory Rate	Breaths:NRat:Pt:Respiratory system:Qn:		LOINC®
8867-4	Heart Rate	Heart beat:NRat:Pt:XXX:Qn:		LOINC®
2710-2	O2 % BldC Oximetry	Oxygen saturation:SFr:Pt:BldC:Qn:Oximetry		LOINC®
8480-6	BP Systolic	Intravascular systolic:Pres:Pt:Arterial system:Qn:		LOINC®
8462-4	BP Diastolic	Intravascular diastolic:Pres:Pt:Arterial system:Qn:		LOINC®
8310-5	Body Temperature	Body temperature:Temp:Pt:^Patient:Qn:		LOINC®
8302-2	Height	Body height:Len:Pt:^Patient:Qn:		LOINC®
8306-3	Height (Lying)	Body height^lying:Len:Pt:^Patient:Qn:		LOINC®
8287-5	Head	Circumference.occipital-		LOINC®

	Circumference	frontal:Len:Pt:Head:Qn:Tape measure		
3141-9	Weight Measured	Body weight:Mass:Pt:Patient:Qn:Measured	Body Weight (Measured)	LOINC®

Table 2-107 Provider Role Value Set Definition¹

Concept Code	Concept Name	Definition
CP	Consulting Provider	Not Available
PP	Primary Care Provider	Not Available
RP	Referring Provider	Not Available

Table 2-109 Provider Type Value Set Definition¹

Concept Code	Concept Name	Definition
	Behavioral Health and Social Service Providers	Not Available
	Chiropractic Providers	Not Available
	Dental Providers	Not Available
	Dietary and Nutritional Service Providers	Not Available
	Emergency Medical Service Providers	Not Available
	Eye and Vision Service Providers	Not Available
	Nursing Service Providers	Not Available
	Pharmacy Service Providers (Individuals)	Not Available
	Allopathic & Osteopathic Physicians	Not Available
	Podiatric Medicine and Surgery Providers	Not Available
	Respiratory, Rehabilitative and Restorative Service Providers	Not Available
	Speech, Language and Hearing Providers	Not Available
	Agencies	Not Available
	Ambulatory Health Care Facilities	Not Available
	Hospitals	Not Available
	Laboratories	Not Available
	Managed Care Organizations	Not Available
	Concept Code Concept Name Definition Nursing and Custodial Care Facilities	Not Available
	Residential Treatment Facilities	Not Available
	Suppliers (including Pharmacies and Durable Medical Equipment)	Not Available
	Physician Assistants and Advanced Practice Nursing Providers	Not Available
	Nursing Service Related Providers	Not Available
	Respite Care Facility	Not Available

Table 2-115 V3 Patient Class Value Set Definition¹

Concept Code	Concept Name	Definition
EMER	Emergency	A patient encounter that takes place at a dedicated healthcare service delivery location where the patient receives immediate evaluation and treatment, provided until the patient can be

		discharged or responsibility for the patient's care is transferred elsewhere (for example, the patient could be admitted as an inpatient or transferred to another facility.)
IMP	inpatient encounter	A patient encounter where a patient is admitted by a hospital or equivalent facility, assigned to a location where patients generally stay at least overnight and provided with room, board, and continuous nursing service
AMB	Ambulatory	A comprehensive term for healthcare provided in a healthcare facility (e.g., a practitioners' office, clinic setting, or hospital) on a nonresident basis. The term ambulatory usually implies that the patient has come to the location and is not assigned to a bed. Sometimes referred to as an outpatient encounter

Table 2-117 Advance Directive Type Value Set Definition¹

Concept Code	Concept Name	Definition	Usage Note
304251008	Resuscitation status (observable entity)	Not Available	Resuscitation
52765003	Intubation (procedure)	Not Available	Intubation
225204009	Intravenous infusion procedures (procedure)	Not Available	IV Fluid and Support
89666000	Cardiopulmonary resuscitation (procedure)	Not Available	CPR
281789004	Antibiotic therapy (procedure)	Not Available	Antibiotics
78823007	Life support procedure (procedure)	Not Available	Life Support

Table 2-126 Document Class Value Set Definition¹

Concept Code	Concept Name (LOINC® Short Name)	Definition (LOINC® Long Common Name)
11369-6	History of Immunizations	
11485-0	Anesthesia Records	Anesthesia records
11486-8	Chemotherapy Records	Chemotherapy records
11488-4	Consultation note	Provider-unspecified consulting note
11506-3	Subsequent evaluation note	Provider-unspecified progress note
11543-6	Nursery Records	Nursery records
15508-5	Labor And Delivery Records	Labor and delivery records
18726-0	Radiology Study Reports	Radiology study reports (set)
18761-7	Transfer summarization note	Provider-unspecified transfer summary
18842-5	Discharge summarization note	Hospital discharge history (narrative)
26436-6	Laboratory Studies	
26441-6	Cardiology Studies	Cardiology studies (set)
26442-4	Obstetrical Studies	Obstetrical studies (set)
27895-2	Gastroenterology Endoscopy Studies	Gastroenterology endoscopy studies (set)
27896-0	Pulmonary Studies	Pulmonary studies (set)
27897-8	Neuromuscular Electrophysiology Studies	Neuromuscular electrophysiology studies (set)
27898-6	Pathology Study Reports	Pathology study reports (set)
28570-0	Procedure note	Provider-unspecified procedure note

28619-5	Ophthalmology/Optometry Studies	Ophthalmology/optometry studies (set)
28634-4	Miscellaneous Studies	Miscellaneous studies (set)
29749-9	Dialysis Records	Dialysis records
29750-7	Neonatal Intensive Care Records	Neonatal intensive care records
29751-5	Critical Care Records	Critical care records
29752-3	Perioperative Records	Perioperative records
34109-9	Evaluation and management note	
34117-2	History and physical note	
34121-4	Interventional procedure note	
34122-2	Pathology procedure note	
34133-9	Summarization of episode note	
34140-4	Transfer of care referral note	
34748-4	Telephone encounter note	
34775-7	Pre-operative evaluation and management note	
47039-3	Admission history and physical note	
47042-7	Counseling note	
47045-0	Study report	
47046-8	Summary of death	
47049-2	Communication	

Table 2-129 Practice Setting Value Set Definition¹

Concept Code	Concept Name	Definition
	Agencies	Not Available
	Ambulatory Health Care Facilities	Not Available
	Hospitals	Not Available
	Laboratories	Not Available
	Managed Care Organizations	Not Available
	Nursing and Custodial Care Facilities	Not Available
	Residential Treatment Facilities	Not Available
	Respite Care Facility	Not Available
	Suppliers (including Pharmacies and Durable Medical Equipment)	Not Available