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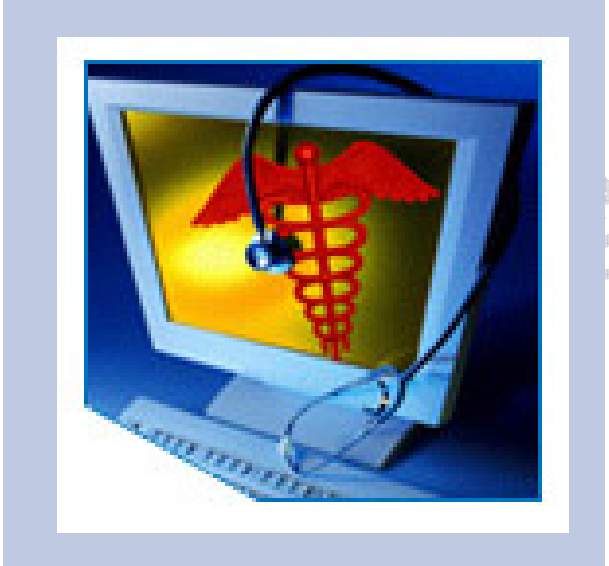
HITSP Interoperability Specification: Registration and Medication History Document(s) Content Component

HITSP/ISC-32



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Healthcare Information Technology Standards Panel

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DOCUMENT CHANGE HISTORY

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1.0	Final Draft	Consumer Empowerment Technical Committee	18-August 2006

1.0 FOREWORD

Healthcare Information Technology Standards Panel (HITSP) is a multi-stakeholder coordinating body designed to provide the process within which affected parties can identify, select, and harmonize standards for communicating healthcare information throughout the healthcare spectrum. HITSP functions as a partnership of the public and private sectors and operates with a neutral and inclusive governance model administered by the American National Standards Institute. The goal of the Panel is to:

- Facilitate the development of harmonized interoperability specifications and information policies, including SDO work products (e.g. standards, technical reports). These policies, profiles and work products are essential for establishing privacy, security and interoperability among healthcare software applications.
- Coordinate, as appropriate, with other national, regional and international groups addressing healthcare informatics to ensure that the resulting standards are globally relevant.
- Be use-case driven, utilize information from stakeholders and base its decisions on industry needs.

The HITSP shall serve the public good by working to ensure that the combined work of various healthcare information standards organizations supports interoperability, accurate use, access, privacy and security of shared health information.

In order to advance the goal of expanding harmonized interoperability specifications and information policies, HITSP was tasked with developing interoperability specifications for three main use case “breakthroughs areas” in which specific, near term value to the health care consumer could be realized. The harmonized use case areas are:

1.	Biosurveillance	Transmit essential ambulatory care and emergency department visit, utilization, and lab result data from electronically enabled health care delivery and public health systems in standardized and anonymized format to authorized Public Health Agencies with less than one day lag time.
2.	Consumer Empowerment	Allow consumers to establish and manage permissions access rights and informed consent for authorized and secure exchange, viewing, and querying of their linked patient registration summaries and medication histories between designated caregivers and other health professionals.
3.	Electronic Health Record	Allow ordering clinicians to electronically access laboratory results, and allow non-ordering authorized clinicians to electronically access historical and other laboratory results for clinical care.

The interoperability specification provides a detailed mapping of existing standards and specifications such as implementation guides, integration profiles to actions and actors that satisfy the requirements imposed by the relevant use cases. It identifies and constrains standards where necessary, and creates groupings of specific actions and actors to further describe the relevant contexts. Where gaps and overlaps are identified, the interoperability specification provides recommendations and a roadmap for corrections to be made.

2.0 INTRODUCTION

The Registration and Medication History Document Content Component describes the document content that summarizes a consumer's registration and medication data information contained within a Personal Health Record (PHR) for the purpose of information exchange. While a PHR can contain much more information, this component only deals with the summary information to and from the PHR.

The registration summary is restricted to the information consumers generally need to provide when visiting a physician, hospital, or pharmacy, such as:

1. demographic information sufficient to help identify the consumer;
2. financial information sufficient for insurance eligibility checking and claims processing; and
3. basic clinical information including allergies.

The registration summary is essentially a subset of the data in a PHR that has been developed for the specific business use case of registration. This subset contains the minimum critical medical information of sections and data elements in a PHR used in that business case.
A registration summary may be prepared using information technology standards developed for a PHR, for example, by creating a view of specific items from the full PHR data set. The resulting registration summary must be a representative extract of the PHR. The information in the registration summary and the full PHR must be consistent. Furthermore there should be no data elsewhere in a PHR that would contradict the meaning of any data in the registration summary.

It is anticipated and desirable that some implementers of the registration summary will want to add data and sections to permit greater communication between a PHR and EHR systems. This practice is beyond the scope of this HITSP component. Implementers must be aware that they must assume that receivers of the document may only be able to view this data, but may not be able to use the additional data in the registration use case. This means that the registration summary must be able to stand-alone. Applications may wish to display the document in two different user-selected views, one of which is restricted to the minimal dataset contents of a registration summary. Adding additional optional sections and data elements should not generate errors. Optional data should be used if understood, but must not change the meaning of the basic registration summary.

With respect to medication history, the summary information about consumers' medications is intended to enable the following activities:

1. create medication history;
2. update medication history;
3. view medication history;
4. physician's review of medication history with consumer, and
5. differentiate current medications from relevant past medications.

The medication history will be the first clinical data section to be added to the core registration summary and illustrates a modular path to a broader PHR information exchange. A core medication summary that answers the question "what medications are you currently taking" is actually part of the HITSP registration and medication history document component summary. A more complete medication history provides additional data to support transfer of clinical care and more complete consumer education and medication management opportunities. Asking a patient about their medications and allergies should be a basic part of all clinical encounters and including this step in an interoperable registration summary is an important tool for improving patient safety and quality of care as well as facilitating electronic prescribing. Making the patient's pharmacies, insurance, and demographics part of the registration summary also allows the registration to facilitate implementation of electronic prescribing by eliminating the need to ask for and enter data need to drive electronic prescribing systems or electronic prescribing functions of an EHR.

Other types of historical medication information, especially those needed to analyze medication compliance and deliver patient education, are important, but are out of scope of this use case.

2.1 OVERVIEW

The Interoperability Specification focuses on a set of constrained standards for information interchange that address the core requirements of the Use Case described herein. It does not define all functions, constructs and standards necessary to implement a conforming system in a real world environment. In particular, an implementer must provide the technical infrastructure and security framework necessary to support operations in accordance with law, regulation, best practices and business agreements.

This document refers to 2006 cycle of the HITSP Consumer Empowerment initiative. It defines the component specification that provides document content specifications for a consumers' registration and medication history information.

2.2 AUDIENCE

The interoperability specification is designed to be used by analysts who need to understand the interoperability requirements for the described use case, and by implementers working to develop

interoperable applications. Understanding and using the relevant interoperability set of specifications is a key requirement for establishing interoperability compliance.

2.3 TERMS AND DEFINITIONS

The definitions used for the purposes of this document can be found in the glossary. Refer to the appendix 6.1 for the glossary.

2.4 CONVENTIONS

This specification uses the following conventions to convey the full descriptions and usage of standards:

Tables

Tables are used to indicate standards categorizations, as well as dependencies and constraints between constructs. Tables are named according to the section in which they reside, and will use the following naming convention:

Table <section number>-<consecutive number for the table, e.g. 1, 2, 3, etc.>. <Short name/description of table>. For example, a table residing in section 2.7.1 showing the Dependencies between the transactions for the Send Lab Results transaction package is named: Table 2.7.1-1. Send Lab Results Transaction Package dependencies

References

When references are made to another section within an Interoperability Specification a section number is used by itself. When references are made to other constructs that are related to the Interoperability Specification, such as Transaction Packages, Components or Composite Standards, the HITSP document short name and section number are displayed as follows:

<HITSP Document short name or Composite Standard Short Name>-<Volume Number>: <section number>

where:

<HITSP document short name> is a short designator for the construct (e.g. HITSP/ISTP-13)

<Composite Standard Short Name> is a short designator for the composite standard (e.g. IHE-ITI TF)

<Volume Number> is the applicable volume within the given composite standard (e.g. 1)

<section number> is the applicable section number (e.g. 3.1)

For example: HITSP/ISTP-13: 3.1 refers to Section 3.1 in the Interoperability Specification for a Transaction Package, IHE-ITI TF-2: 4.33 refers to Section 4.33 in volume 2 of the IHE IT Infrastructure Technical Framework.

Reproductions

Where large sections of composite standards or base standards are reproduced within a HITSP specification, the reproduced sections are cited with introductory text containing the reference information for the composite or base standard. In addition, the beginning and ending of the reproduced text are respectively shown using a beginning statement:

The text for the <composite or base standard name> specification begins here:

And an ending statement:

The text for the <composite or base standard name> ends here.

2.5 COMMENTS

To submit comments for this interoperability specification, please download the Comment Submission sheet from the HITSP site at www.hitsp.org and provide all relevant information, and then email the completed document to hitspcomments@ansi.org. Comments are consolidated periodically and sent to the Technical Committees for review.

2.6 COPYRIGHT PERMISSIONS

3.0 STANDARDS REFERENCES

It is HITSP's policy to only incorporate standards that have been approved according to the formal policy of the standards development organization that publishes the standard. HITSP interprets approval to include standards for trial use. The objective is to incorporate only standards that are managed within a formal life cycle process as defined by the SDO. In some cases, where we believe a not-yet-approved standard best meets the requirements of an Interoperability Specification, HITSP may provisionally select and conditionally use such standard subject to the following:

- The standard is approved by the time that the Interoperability Specification is released by HITSP.
- The standard approved is substantially the same as it was when provisionally used.

If either condition is not met at the date of the HITSP Interoperability Specification release, HITSP may continue to use the "standard" as it was in its provisional state until such time as HITSP can replace it with a more suitable artifact. In this circumstance, the SDO would have no responsibility to maintain or correct this artifact.

The Consumer Empowerment Technical Committee (CETC) has been charged with introducing the consumer, and the PHR, as an integral partner of the healthcare information flow representing a new paradigm in healthcare interoperability. This paradigm establishes the consumer as the active participant in health information exchange that touches all segments of the industry: providers/care facilities, health plans, pharmacies/prescription benefit managers (PBM), and others. This challenge is exacerbated by the current information technology situation wherein providers, health plans, and pharmacies/PBMs industry segments each have independently selected different standards with overlapping data elements from three different standards developers: HL7, ASC X12, and NCPDP.

In addition to these aforementioned standards, a fourth standard initiative from ASTM targeting the provider-provider and provider-consumer interoperability space, entitled the Continuity of Care (CCR), passed favorable ballot in October 2005. In the latter phase of the successful CCR balloting process, ASTM and HL7 initiated a formal harmonization effort regarding their respective efforts addressing the same interoperability space. This harmonization initiative resulted in the joint development of the Continuity of Care Document (CCD) which was issued as an HL7 ballot in August 2006.

The CETC has determined that it is in the best interest of HITSP harmonization efforts to wholeheartedly support this HL7-ASTM harmonization initiative and leverage its deliverables to the highest degree possible. To this end, in the absence of having a balloted CCD standard to reference, the approach taken by the CETC is to align its Interoperability Specification to the expected technical design characteristics of the CCD. This CE Interoperability Specification

artifact is therefore intended to facilitate the transition from the current disparate standards environment to a harmonized state through use of an interim specification that is on the convergence path of the promised HL7-ASTM harmonization. HITSP is committed to migrate this interim specification to the final balloted result of this HL7-ASTM harmonization work as soon as it's officially available.

As an interim specification, the CETC has chosen the "Integrating the Healthcare Enterprise (IHE) Technical Framework (TF) for the Exchange Personal Health Record (XPHR)" profile as its primary source of data element specifications. The XPHR TF itself is a reconciliation of current industry activities for describing the PHR elements and their use in a registration and medication history information exchange. Contributing standards/publications to this TF include AHIMA PHR Common Data Elements, HL7 CDA R2, and the current HL7 CCD ballot, whereby the CCD has been recognized as a CDA instance of the CCR standard. Where necessary, this CE interim specification has constrained the published XPHR TF to appropriately satisfy the interoperability requirements of the CE Use Case. Such data element constraints provide relevant feedback to the HL7 and ASTM SDOs for their joint standards development activities.

As noted in the initial paragraph, the CETC has also recognized the need to ensure consistency of its specified data elements across all the standards deployed by the business actors of the Use Case which are potential sources of data in the PHR. For example, ASC X12 is used to describe health plan information that is relevant for updating a consumer's PHR. To this end, this HITSP Interoperability Specification Registration / Medication History Content Component includes appendices for informative data element cross-mapping tables between its own elements and the ASTM CCR, ASC X12, and NCPDP Script 8.1 data elements for all common content areas. These element mapping tables will serve as guidance to the SDOs and/or application system vendors using these base standards as to how to adapt these standards and their implementations to the HITSP interoperability specification.

3.1 LIST OF BASE STANDARDS

Table 3.1-1 documents the base standards needed to implement this component.

Context Standards	
Standard	Description
ASTM E 2369-05 – Standard Specification for Continuity of Care Record (CCR)	The Continuity of Care Record (CCR) is a core data set of the most relevant and timely facts about a patient's healthcare. It is to be prepared by a practitioner at the conclusion of a healthcare encounter in order to enable the next practitioner to readily access such information. It includes a summary of the patient's health status (e.g., problems, medications, allergies) and basic information about insurance, advance directives, care documentation, and care plan recommendations.

ASC X12 Standards Release 004010	Release (version) 004010 of the ANSI-chartered 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.
Health Level Seven (HL7) CDA R2	The HL7 Clinical Document Architecture (CDA) is a document markup standard that specifies the structure and semantics of "clinical documents" for the purpose of exchange. The CDA Release 2.0 distribution includes a prose document in HTML, XML schemas, data dictionary, and sample CDA documents. The HL7 CDA Release 2.0 standard builds upon other HL7 standards, including the HL7 Version 3 Reference Information Model (RIM), Data Structures, Vocabulary, and the XML Implementation Technology Specifications for Data Types and V3 Structures.
National Council for Prescription Drug Programs SCRIPT Standard V 8.1	The NCPDP SCRIPT Standard provides for the exchange of new prescriptions, changes, renewals, cancellations, and fill status notifications. Each function has varying degrees of industry experience. The NCPDP SCRIPT new prescription function is most widely used. The renewal function has good industry acceptance, represents an easy transition, and provides the most immediately apparent return on investment. The NCPDP SCRIPT Standard cancellation and change functions are currently underutilized.
Information Interchange Standards	
Standard	Description
	None Used
Terminology Standards	
Standard	Description
ASTM E 2369-05 – Standard Specification for Continuity of Care Record (CCR)	The Continuity of Care Record (CCR) is a core data set of the most relevant and timely facts about a patient's healthcare. It is to be prepared by a practitioner at the conclusion of a healthcare encounter in order to enable the next practitioner to readily access such information. It includes a summary of the patient's health status (e.g., problems, medications, allergies) and basic information about insurance, advance directives, care documentation, and care plan recommendations.
ASTM-E1633	Standard Specification for Coded Values Used in the Electronic Health Record
ASC X12 Standards Release 004010	Release (version) 004010 of the ANSI-chartered 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.
Health Level Seven (HL7) version 3.0 Vocabulary	The HL7 Vocabulary standard includes listing of all vocabularies used in the HL7 standard. This includes structured vocabulary that defines the relationships between classes in the RIM and Code Set Vocabularies used to define attribute code sets.

Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity	This classification provides a minimum standard for maintaining, collecting, and presenting data on race and ethnicity for all Federal-reporting purposes. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies.
SNOMED CT®	SNOMED CT® is the universal health care terminology that makes health care knowledge usable and accessible wherever and whenever it is needed. This strong foundation is leading the health care industry in building a seamless infrastructure of worldwide care while integrating an overwhelming amount of clinical data.
Security Standards	
Standard	Description
Not Applicable	Security is considered a pre-conditions, therefore are not listed in this specification.
Identifier Standards	
Standard	Description
	None Used
Functionality and Process/Process and Workflow Standards	
Standard	Description
CORE Phase I Operating Rules	The Committee on Operating on Rules for Information Exchange (CORE) Phase 1 Operating Rules provides operating rules and guidelines for giving providers access to eligibility and benefits information before or at the time of service using the electronic system of their choice for any patient or health plan.
Legislative Standards	
Standard	Description
	None Used
Other Standards	
Standard	Description
	None Used

310 Table 3.1-1 –1 Base Standards List

3.2 LIST OF COMPOSITE STANDARDS

Table 3.2-1 lists and describes the composite standards used by this component.

Composite Standard	Description
CORE Phase I Operating Rules	The Committee on Operating on Rules for Information Exchange (CORE) Phase 1 Operating Rules provides operating rules and guidelines for giving providers access to eligibility and benefits information before or at the time of service using the electronic system of their choice for any patient or health plan.

Composite Standard	Description
Federal Medication Terminologies	A set of federal terminologies related to medications, including the Food and Drug Administration's names and codes for ingredients, manufactured dosage forms, drug products and medication packages, the National Library of Medicine's RxNORM for describing clinical drugs, and the Veterans Administration's National Drug File Reference Terminology (NDF-RT) for specific drug classifications. This leverages the controlled terminology from three medication models that are maintained by the federal government: National Drug File Reference Terminology (NDF-RT) • Veterans Health Administration Structured Product Labeling (SPL) • Food and Drug Administration RxNorm • National Library of Medicine
Integrating the Healthcare Enterprise (IHE) Patient Care Coordination (PCC) Technical Framework Revision 1.0	The IHE Patient Care Coordination Technical Framework (PCC TF) defines specific implementations (called profiles) of established standards to deal with integration issues that cross providers, patient problems or time.
Integrating the Healthcare Enterprise (IHE) Patient Care Coordination (PCC) - Exchange of Personal Health Record Content (XPHR) Profile Supplement for Trial Implementation	The Exchange of Personal Health Record Content (XPHR) integration profile describes the content and format of summary information extracted from a PHR system for import into an EHR system, and visa versa. The purpose of this profile is to support interoperability between PHR systems used by patients and EHR systems used by healthcare providers.
X12N 270/271 Version 004010A1 Implementation Guide	The HIPAA-named implementation guides to be used for healthcare eligibility and benefits data exchange between healthcare providers (e.g. dentists, professionals, institutions), health plans, pharmacy benefit managers (PBM) and healthcare clearinghouses.

Table 3.2-1 List of Composite Standards

4.0 COMPONENT

Components define atomic constructs used to support an information exchange or to meet an infrastructure requirement (e.g., security, logging/audit). This is accomplished by:

(a) Referencing one or more underlying standards, and
(b) Specifying constraints and other rules for using the standards

4.1 CONTEXT OVERVIEW

The Registration and Medication History Document Content Component describes the document content that summarizes a consumer's registration and medication data information contained

within a PHR. While a PHR can contain much more information, this component only deals with the summary information coming from and returning to the PHR.

4.1.1 CONTEXTUAL CONSTRAINTS

All constraints to this component are defined in the Data Mapping sections beginning with 4.2.3.1.

4.1.2 TECHNICAL ACTORS

No technical actors are contained in this document. Application technical actors are described in higher-level specifications that incorporate this component.

4.2 INFORMATION INTERCHANGE COMPONENTS: RULES FOR IMPLEMENTING

The following sections document the content of the Registration and Medication History component. It provides the basics elements and secondary standards that are supported by this component and the constraints that are being placed on those standards.

4.2.1 PROCESS PRE-CONDITIONS AND TRIGGERS

No process pre-conditions or triggers are contained in this document. Application process pre-conditions and triggers are described in higher-level specifications that incorporate this component.

4.2.2 PROCESS POST-CONDITIONS AND OUTPUTS

No process post-conditions or outputs are contained in this document. Application process post-conditions and outputs are described in higher-level specifications that incorporate this component.

4.2.3 DATA STRUCTURE

This component uses tables to provide the content of the Registration/Medication History summary. Requirement types are defined for various entries in the tables. The convention for this is defined below.

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
1.01	Name xxx	R/Y	cda:recordTarget/cda:patientRole/ cda:patient/cda:name	None
1.02	.....	.....	.....	.....

Table 4.2.3-1 Table conventions

Table Headings:

Data Elem. ID –a numeric identification of the data element, can be used for referencing this data element in this document only

Data Elements – the name of the data element being defined

HITSP Opt/Repeat – two fields where the first defines the Requirement Type and the second a Repeating Definitions

CCD/XPHR Name – the CCD/XPHR XPath name

HITSP Additional Specification Reg/Med component – specifies HITSP requirements and restriction, if needed

Requirement Type Definitions:

R = Required if known
Required data elements must always be sent. Data elements that are required may under exceptional circumstances have an unknown value (e.g., the name of an unconscious patient). In these cases the sending application is required to indicate the reason that the data is not available.

R2 = Required if known
Data elements that are marked required if known (R2) must be sent when the sending application has that data available. The sending application must be able to demonstrate that it can send all required if known elements, unless it does not in fact gather that data. When the information is not available, the sending application may indicate the reason that the data is not available.

O = Optional
Data elements that are marked optional (O) may be sent at the choice of the sending application. An optional element need not be sent, but when it is sent, the content module defines the meaning of that data element, and a receiver can always be assured of what that data element represents when it is present. Senders should not send an optional data element with an unknown value. If the value is not known, simply do not send the data element.

Other data elements not defined in this component may be included in an instance of a content module. Receivers are not required to process these elements, and if they do not understand them, must ignore them. Thus, it is not an error to include more than is asked for, but it is an error to reject a content module because it contains more than is defined by the framework.

If a data element coded value may be derived from another data element coded value, the creator of this component shall ensure the accuracy and consistency between the two data elements. If the receiver detects an inconsistency it shall not correct the value without human intervention.

Whether a module or element may be repeated is defined for various entries in the tables. The convention for this is defined as Y = Yes, N = No.

4.2.3.1 DATA MAPPING

Table 4.2.3.1-1 defines the Content Modules used by this component.

Below Table 4.2.3.1-1 is a set of two related tables. The tables are based upon the IHE-CCD/XPHR document specification for a PHR extract. The first table specifies the data elements within each Content Module and their definitions. The second table specifies the same data elements and defines their optionality, repeatability, the CCD/XPHR name and any HITSP additional requirements and/or restrictions (if needed).

Content Modules	CCD/ XPHR Opt	HITSP Opt	HITSP Repeat	Specification Reference	HITSP Additonal Specification for Reg/Med Component
Personal Information	R	R	N	See CCD: 2.5 See XPHR: 5.4.2.1	See section 4.2.3.1.1
Languages Spoken	R2	R2	Y	See XPHR: 5.4.2.2	See section 4.2.3.1.2
Support	R2	R2	Y	See CCD: 3.3 See XPHR: 5.4.2.7	See section 4.2.3.1.3
Healthcare Provider	R	R	Y	See CCD: 3.17 See XPHR: 5.4.2.4 and 5.4.2.6	See section 4.2.3.1.4
Insurance Provider	R2	R2	Y	See CCD: 3.1 See XPHR: 5.4.2.4	See section 4.2.3.1.5
Allergies and Drug Sensitivity	R	R	Y	See CCD: 3.8 PCC TF:2 5.4.3.2.9	See section 4.2.3.1.6
Condition	R	R	Y	See CCD: 3.5 PCC TF:2 5.4.3.2.5 PCC TF:2 5.4.3.2.3	See section 4.2.3.1.7
Medications – Prescription and Non-Prescription	R	R	Y	See CCD: 3.9 PCC TF:2 5.4.3.3.1	See section 4.2.3.1.8
Pregnancy	O	O	N	See XPHR: 5.4.3.2.2	See section 4.2.3.1.9
Information Source	O	R	N	PCC TF-2: 5.4.4.5.2	See section 4.2.3.1.10
Comments	O	O	Y	HL7 CDAR2: 4.3.7.1 and 4.3.8.5	See section 4.2.3.1.11
Advance Directives	O	O	Y	*N/A*	See section 4.2.3.1.12

Table 4.2.3.1-1 Reg/Med History Document History Content Modules

4.2.3.1.1 Person Information Module

This module provides the name, address, contact information, personal identification information; ethnic and racial affiliation, and marital status of the person who is the subject of this registration / medication history document.

– Adapted from XPHR

Data Elem. ID	Data Element	Definition
1.01	Document Timestamp	The date and time that this Registration Summary and Medication History document (herein Reg/Med Doc) has been created.
1.02	Person Name	The individual to whom the Reg/Med Doc refers. Multiple names are allowed to retain birth name, maiden name, legal names, and aliases as required.
1.03	Person Address	The current address of the individual to which the Reg/Med Doc refers. Multiple addresses are allowed and the work address may be a method of disclosing the employer.
1.04	Person Phone/Email/URL	A telephone number (voice or fax), e-mail address, or other locator for a resource mediated by telecommunication equipment. One object class is used to describe phone numbers, pagers, Email addresses, and URLs. The patient may designate one of more of these contact numbers as the preferred methods of contact and temporary items can be entered for use on specific effective dates.
1.05	Person ID	An identifier that uniquely identifies the individual to which the Reg/Med doc refers. Potential security risks associated with use of SSN or driver's license for this element suggest that these should not be used routinely.
1.06	Person Date of Birth	The date and time of the birth of the individual to which this Reg/Med Doc refers. The date of birth is typically a key patient identifier variable and used to enable computation of age at the effective date of any other data element. It is assumed to be unique and fixed throughout the patient's lifetime.
1.07	Gender	Gender is used to refer to administrative sex rather than biological sex and therefore should easily be classified into female and male. It is included in the registration summary for purposes of linking to insurance information and other patient identification linkages and the value chosen by the patient should reflect the information under which any insurance or financial information will be files as well as the same information given to other health care providers, institutions, or health data exchange networks.
1.08	Marital Status	A value representing the domestic partnership status of a person. Marital status important in determining insurance eligibility and other legal arrangements surrounding care. Marital status often changes during a patient's lifetime so the data should relate to the effective date of the patient data object and not entered with multiple values like an address or contact number. This element should only have one instance reflecting the current status of the individual at the time the Reg/Med Doc is produced. Former values might be part of the personal and social history in a full PHR but are not to be included for registration summary purposes.
1.09	Race	Race is normally a single valued term that should be constant over that patient's lifetime. The coding of race and ethnicity should be aligned with public health and other Federal reporting standards of the CDC and the Census bureau. Typically the patient is the source of the content of this element. However, the individual may opt to omit race from the Reg/Med Doc. In this event, some health care organizations who receive the summary may choose to enter an observed race as may be their current practice for manual registration. Such organization observed race data should be differentiated from a patient sourced in the patient's registration summary.
1.10	Ethnicity	Ethnicity is a census counting term that extends the concept of race and allows entry of an ethnicity, such as Hispanic, as a separate dimension that may be combined with any race. Whereas race is biological, ethnicity is cultural.

435 Table 4.2.3.1.1-1 Person Information Data Element Definitions

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
1.01	Document Timestamp	R/Y	/cda:ClinicalDocument/cda:time	None
1.02	Person Name	R/Y	cda:recordTarget/cda:patientRole/ cda:patient/cda:name	None
1.03	Person Address	R/Y	cda:recordTarget/cda:patientRole/ cda:addr	None
1.04	Person Phone/Email/URL	R/Y	cda:recordTarget/cda:patientRole/ cda:telecom	None
1.05	Person ID	R/Y	cda:recordTarget/cda:patientRole/ cda:id	None
1.06	Person Date of Birth	R/N	cda:recordTarget/cda:patientRole/ cda:patient/cda:birthTime	None
1.07	Gender	R/N	cda:recordTarget/cda:patientRole/ cda:patient/ cda:administrativeGenderCode	See 4.2.3.1.1.1
1.08	Marital Status	R2/N	cda:recordTarget/cda:patientRole/ cda:patient/ cda:maritalStatusCod	See 4.2.3.1.1.2
1.09	Race	O/Y	cda:recordTarget/cda:patientRole/ cda:patient/ cda:raceCode	See 4.2.3.1.1.3
1.10	Ethnicity	O/N	cda:recordTarget/cda:patientRole/ cda:patient/ cda:ethnicityCode	See 4.2.3.1.1.4

Table 4.2.3.1.1-1 Person Information Data Element Requirements

4.2.3.1.1.1 Gender Constraints

Gender shall be coded using the HL7 AdministrativeGenderCode terminology.

4.2.3.1.1.2 Marital Status Constraints

Marital Status shall be coded using the vocabulary for marital status defined in ASTM E1633. The OID for this terminology is 2.16.840.1.113883.3.88.32.1.8.

NOTE TO COMMENTERS: Due to limitations in the base standard, the following two terminologies have been developed for reporting race and ethnicity in a CDA Release 2.0 document. We welcome comments on the suitability of this solution for this content component. There were two alternative solutions offered by the HL7 Structured Documents Technical Committee, one of which was rejected by other technical committees within HL7. The remaining solution is to create an extension to CDA Release 2.0 to support reporting using a more complex terminology for Race and Ethnicity (e.g. the CDC Race and Ethnicity Code Set).

4.2.3.1.1.3 Race Constraints

Race shall be coded according to Federal Guidelines for reporting race. These guidelines require classification to one of five race classifications, with multiple classifications being possible. The terminology in the table below meets these minimum requirements using 32 distinct codes. Codes longer than a single letter are used to report multiple classifications being used. Note, the owner of the PHR need not divulge their racial background, in which case the code N should be used. The OID for this terminology is 2.16.840.1.113883.3.88.32.1.9.

Code	Description
A	American Indian or Alaskan Native
B	Black or African American
H	Native Hawaiian or Pacific Islander
I	Asian
W	White
N	Not reported
AB	Both A and B above
AH	Both A and H above
AI	Both A and I above
AW	Both A and W above
BH	Both B and H above
BI	Both B and I above
BW	Both B and W above
HI	Both H and I above
HW	Both H and W above
IW	Both I and W above

Code	Description
ABH	A, B and H above
ABI	A, B and I above
ABW	A, B and W above
AHI	A, H and I above
AHW	A, H and W above
AIW	A, I and W above
BHI	B, H and I above
BHW	B, H and W above
BIW	B, I and W above
HIW	H, I and W above
ABHI	A, B, H and I above
ABHW	A, B, H and W above
ABIW	A, B, I and W above
ABHI	A, B, H and I above
BHIW	B, H, I and W above
ABHIW	A, B, H, I and W above

Table 4.2.3.1.1.3-1 Terminology for Reporting Race

4.2.3.1.1.4 Ethnicity Constraints

Ethnicity shall be coded according to Federal Guidelines for reporting ethnicity. These guidelines require classification to one of two ethnicity classifications: Hispanic or Non-Hispanic. Multiple classifications may be reported. The Note, the owner of the PHR need not divulge their ethnic background, in which case the code N should be used. The OID for this terminology is 2.16.840.1.113883.3.88.32.1.10 using the following values.

Code	Description
H	Hispanic
N	Not Reported
O	Not Hispanic
B	Of both Hispanic and Non-Hispanic Origin

Table 4.2.3.1.1.4-1 Terminology for Reporting Ethnicity

4.2.3.1.2 Language Spoken Module

This module describes the primary and secondary languages of communication for the patient.
– Adapted from XPHR

Data Elem. ID	Data Element	Definition
2.01	Language	Language will be identified as spoken, written, or understood; but no attempt will be made to assess proficiency. The default language is English, but English is to be entered explicitly similar to any other listed language. Languages spoken shall be recorded using the languageCommunication infrastructure class associated with the patient. The languageCommunication element describes the primary and secondary languages of communication for a person.

Table 4.2.3.1.2-1 Language Spoken Data Element Requirements

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
2.01	Langauge	R/Y	cda:recordTarget/cda:patientRole/ cda:patient/ cda:languageCommunication	None

Table 4.2.3.1.2-2 Language Spoken Data Element Requirements

4.2.3.1.3 Support Module

Represents the patient's sources of support such as immediate family, relatives, and guardian at the time the summarization is generated. Support information also includes next of kin, caregivers, and support organizations. At a minimum, key support contacts relative to healthcare decisions, including next of kin, should be included. – Adapted from CCD.

The contact data object is used to store phone numbers, Email, and URL information for contacting the patient or others such as emergency contacts or health care providers.

Data Elem. ID	Data Element	Definition
3.01	Date	The period over which the support is provided.
3.02	Contact Type	This represents the type of support provided, such as immediate emergency contacts, next of kin, family relations, guardians, agents, et cetera.
3.03	Contact Name	The name of the individual or organization providing support to the individual for which this Reg/Med Doc is produced.
3.04	Contact Address	The address of the individual or organization providing support to the individual for which this Reg/Med Doc is produced. .
3.05	Contact Phone/Email/URL	The contact numbers of the individual or organization providing support to the individual for which this Reg/Med Doc is produced. One object class is used to describe phone numbers, pagers, Email addresses, and URLs.
3.06	Contact Relationship	Identifies the relationship of the contact person to the individual for which this Reg/Med Doc refers.

Table 4.2.3.1.3-1 Support Module Data Element Definitions

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
3.01	Date	R/N	cda:participant/cda:time	None
3.02	Contact Type	R/N	cda:participant/ cda:associatedEntity/@classCode	See 4.2.3.1.4.1
3.03	Contact Name	R/Y	cda:participant/ cda:associatedEntity/ cda:associatedPerson/cda:name	None
3.04	Contact Address	R2/Y	cda:participant/ cda:associatedEntity/cda:addr	None
3.05	Contact Phone/Email/URL	R2/Y	cda:participant/ cda:associatedEntity/cda:telecom	None
3.06	Contact Relationship	R2/N	cda:participant/cda:associatedEntity/cda: code	See 4.2.3.1.4.2

Table 4.2.3.1.3-2 Support Module Data Element Requirements

4.2.3.1.3.1 Contact Type

Contact type is expressed by the classCode attribute. This attribute comes from the HL7 RoleClass vocabulary component. For this specification, the following values will be used to express different types of contacts:

Term	HL7 Definition	Clarification for use in the CE Context
AGNT	An entity that acts or is authorized to act on behalf of another entity (scoper).	Used to record persons which can act on behalf of the patient, e.g., someone holding a healthcare power of attorney, et cetera.
CAREGIVER	A person responsible for the primary care of a patient at home.	None
ECON	An entity to be contacted in the event of an emergency.	None
GUARD	Guardian of a ward	Not used in this context, as CCD specifies that the guardian relationship shall be encoded using the <cda:guardian> element that appears inside the <cda:patient> element.
NOK	An individual designated for notification as the next of kin for a given entity.	None
PRS	Links two people in a personal relationship.	Used to describe family members and other persons that have a personal relationship with the patient. When this value is used, the value used for Contact Relationship below is also constrained to the HL7 PersonalRelationshipRoleType vocabulary domain.

Table 4.2.3.1.3.1-1 Contact Type Additional Specifications

4.2.3.1.4 Healthcare Providers Module

This module represents the healthcare providers involved in the current or pertinent historical care of the patient. – Adapted from CCD

Data Elem. ID	Data Element	
4.01	Date Range	The period over which this provider has provided healthcare services to the patient.
4.02	Provider Type	Provider type classifies providers according to the type of license they hold (e.g. physician, dentist, pharmacist, et cetera).
4.03	Provider Role Coded	Provider role used a coded value to classify providers according the the role they play in the healthcare of the patient, normally expressed by their specialty (e.g., primary care, ob/gyn, cardiologist, neurologist, et cetera).
4.04	Provider Name	The name of the provider.
4.05	Provider Address	The mailing address to which written correspondence to this provider should be directed.
4.06	Provider Phone/Email/URL	A telephone number (voice or fax), e-mail address, or other locator for a resource mediated by telecommunication equipment. One object class is used to describe phone numbers, pagers, Email addresses, and URLs. One or more of these contact numbers can be designated as the preferred methods of contact; temporary items can be entered for use on specific effective dates.
4.07	Provider's Organization Name	The name of the organization with which the provider is affiliated. While providers may be affiliated with more than one organization, this should be the organization affiliated with this person's care.
4.08	Provider's Patient ID	The identifer used by this provider to identify the patient's medical record.
4.09	Provider Role Free Text	This unstructured text classifies providers according the the role they play in the healthcare of the patient, normally expressed by their specialty (e.g., primary care, ob/gyn, cardiologist, neurologist, et cetera).

Table 4.2.3.1.4-1 Health Care Providers Data Element Definitions

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
4.01	Date Range	R/N	cda:participant/cda:time	None
4.02	Provider Type	R2/N	cda:performer/cda:code	See 4.2.3.1.4.1
4.03	Provider Role Coded	R2/N	cda:performer/ cda:assignedEntity/ cda:functionCode	See 4.2.3.1.4.2
4.04	Provider Name	R2[1]	cda:performer/ cda:assignedEntity/ cda:assignedPerson/cda:name	None
4.05	Provider Address	R2/Y	cda:performer/ cda:assignedEntity/cda:addr	None
4.06	Provider Phone/Email/URL	R2/Y	cda:performer/ cda:assignedEntity/cda:telecom	None
4.07	Provider's Organization Name	R2[1]/Y	cda:performer/ cda:assignedEntity/cda:id	None
4.08	Provider's Patient ID	R2	cda:performer/ cda:assignedEntity/ pcc:patient/pcc:id	None
4.09	Provider Role Free Text	R2	cda:performer/cda:code/cda:originalText	None

Table 4.2.3.1.4-2 Health Care Providers Data Element Requirements

4.2.3.1.4.1 Provider Type

Provider type shall be coded using a subset of the HL7 ProviderCodes terminology. This subset uses only the high-level provider codes, and eliminates a few codes not otherwise needed in the CE use case. The OID for this terminology is 2.16.840.1.113883.6.101.

[1] At least one of the provider names and provider organizations shall be provided.

Term	HL7 Definition
100000000X	Behavioral Health and Social Service Providers
110000000X	Chiropractic Providers
120000000X	Dental Providers
130000000X	Dietary and Nutritional Service Providers
140000000X	Emergency Medical Service Providers
150000000X	Eye and Vision Service Providers
160000000X	Nursing Service Providers
180000000X	Pharmacy Service Providers
200000000X	Allopathic & Osteopathic Physicians
210000000X	Podiatric Medicine and Surgery Providers
220000000X	Respiratory, Rehabilitative and Restorative Service Providers
230000000X	Speech, Language and Hearing Providers
250000000X	Agencies
260000000X	Ambulatory Health Care Facilities
280000000X	Hospitals
290000000X	Laboratories
300000000X	Managed Care Organizations
310000000X	Nursing and Custodial Care Facilities
320000000X	Residential Treatment Facilities
360000000X	Physician Assistants and Advanced Practice Nursing Providers
370000000X	Nursing Service Related Providers
380000000X	Respite Care Facility

Table 4.2.3.1.3.1-1 Provider Type Additional Specifications

NOTE TO COMMENTERS: The HIPAA Provider Taxonomy was briefly considered for use for this terminology, as it very nearly identifies the roles (although as specialties). However, the way a healthcare provider identifies themselves is not the same as how consumers identify their providers. The CETC also felt it necessary to preempt the temptation to use consumer supplied role information in HIPAA mandated transactions, as the way consumers identify providers has to do with the functional role that they serve, while the HIPAA Provider taxonomy serves to identify providers by their structural role. For example, a consumer may identify their "Cardiologist" as a provider (who may have given service for a cardiac condition) that is not necessarily board certified in Cardiology. The following terminology is derived from the HL7 Healthcare Scenario Roadmap as being more appropriate for consumer use. HL7 has not yet published this list in their vocabulary standard, so the CETC has found it necessary to create this vocabulary for the interim.

4.2.3.1.4.2 Provider Role

Provider role shall be taken from the terminology specified below. The OID for this terminology is 2.16.840.1.113883.3.88.32.4.3.

Code	Description
1001	Audiologist
1002	Dental Hygienist/Registered Dental Hygienist (RDH)
1003	Dentist (DDS or DMD)
1004	Dentist
1005	Oral Surgeon
1007	Non-western Medicine Providers
1008	Certified Acupuncturist (CA)
1009	Licensed Massage Therapist (LMT)/Registered Massage Therapist (RMT)
1010	Nurse
1011	Clinical Nurse Specialist (CNS)
1012	Clinical Registered Nurse Anesthetist (CRNA)
1013	Licensed Vocational Nurse (LVN)/Licensed Practical Nurse (LPN)
1014	Nurse Midwife (NM)
1015	Nurse Practitioner (NP)
1016	Registered Nurse (RN)
1017	Optometrist (OD)
1018	Pharmacist
1019	Pharmacist, Apothecary
1020	Pharmacist, Clinical
1021	Physician
1022	Chiropractor (DC)
1023	DO/Osteopath
1024	Homeopath
1025	MD/Allopath
1026	Naturopath
1027	Pathologist
1028	Podiatrist (DPM)
1029	Psychiatrist
1031	Physician Assistant (PA)
1032	Psychologist
1034	Speech Pathologist
1035	Technician
1036	Cardiology Technician
1037	Medical Laboratory Technician (MLT)
1038	Pharmacy Technician
1039	Prosthetic Technician
1040	Technologist
1041	Cytotechnologist
1042	Laboratory Technologist
1043	Medical Technologist (MT)
1044	Radiologic Technologist

Code	Description
1045	Therapist
1046	Certified Educational Therapist (CET)
1047	Kinesiotherapist (KT or RKT)
1048	Musical Therapist
1049	Occupational Therapist (OTR/L)
1050	Occupational Therapy Assistant
1051	Physical Therapist (PT or RPT)
1052	Physical Therapy Assistant
1053	Recreational Therapist (RT)
1054	Respiratory Therapist
1055	Speech Therapist
1056	Vocational Therapist
1057	Other

Table 4.2.3.1.4.1-1 – Provider Role Terminology

4.2.3.1.5 Insurance Providers Module

This Insurance Providers Module contains data about the entities or other individuals who may pay for a patient's health care. Such entities or individuals may be health insurance plans, other payers, guarantors, parties with financial responsibility, some combination of payers, or the patient directly. This module is used to define which entity or combination of entities has any financial responsibility for a patient's care.

Each unique instance of a payer or party with financial responsibility will include all the pertinent data needed to contact, bill to, and collect from that party. At a minimum, the patient's pertinent current payment sources should be listed.

Data Elem. ID	Data Element	Definition
5.01	Health Plan Begin Date	The begin date of the health plan covering the individual. This date may not apply equally to all benefits included in the health plan coverage, since some benefits may have waiting periods for coverage to be effective which results in a different benefit begin date.
5.02	Health Insurance Type	The type of health plan covering the individual, e.g., an HMO, PPO, POS, Medicare Part A/B, etc.
5.03	Financial Responsibilty Party Type	The type of party that has responsibility for all or a portion of the patient's health care; includes health insurance, the patient directly, a guardian or other guarantor, or other third party that is not a health insurance plan.
5.04	Health Plan Insurance Information Source Name	The name of the entity that pays for the health insurance. This name is not synonymous with a Health Plan Name or a health plan identifier (when/if health plans are enumerated under HIPAA). In the context of the 271, an information source could be the payer, a third party administator (TPA), a health plan sponsor, or a gateway provider.
5.05	Health Plan Name	The name of the specific health insurance product as specified by the insurance company offering the health care insurance. The HIPAA legislation requires the Secretary of HHS to establish unique health plan identifiers. To date regulations specifying the enumeration and identification of health plans have not been promulgated by the Secretary of HHS.
5.06	Health Plan Insurance Information Source Address	The official mailing address to which written correspondence is to be directed.

Data Elem. ID	Data Element	Definition
5.07	Health Plan Insurance Information Source Phone/Email/URL	A telephone number (voice or fax), e-mail address, or other locator for a resource mediated by telecommunication equipment. One object class is used to describe phone numbers, pagers, Email addresses, and URLs. One or more of these contact numbers can be designated as the preferred methods of contact; temporary items can be entered for use on specific effective dates.
5.08	Health Plan Insurance Information Source ID	The coded identifier of the payer corresponding to the Health Plan Information Source Name. It is important to note that Health Plan Information Source Name and ID are NOT synonymous with Health Plan Name or the health plan identifier (when/if health plans are enumerated under HIPAA).
5.09	Subscriber Name	The name of the actual member or health plan contract holder (the true subscriber) as entered into the eligibility system of the health plan. This is not the name of a related spouse, child, or dependent. See section 4.2.3.1.5.1
5.10	Subscriber Date of Birth	The date of birth of the actual member or health plan contract holder (the true subscriber) as entered into the eligibility system of the health plan. See section 4.2.3.1.5.2
5.11	Subscriber Address	The official mailing address of the actual member or health plan contract holder (the true subscriber) as entered into the eligibility system of the health plan to which written correspondence is to be directed.
5.12	Subscriber Phone/Email/URL	A telephone number (voice or fax), e-mail address, or other locator for a resource mediated by telecommunication equipment. One object class is used to describe phone numbers, pagers, Email addresses, and URLs. One or more of these contact numbers can be designated as the preferred methods of contact; temporary items can be entered for use on specific effective dates.
5.13	Group Number	The policy or group contract number identifying the contract between a health plan sponsor and the health plan. This is not a number that uniquely identifies either the subscriber or person covered by the health insurance.
5.14	Subscriber ID	The identifier assigned by the health plan to the actual member or health plan contract holder (the true subscriber) entered into the eligibility system of the health plan. A related spouse, child, or dependent may be identified through the subscriber's identification number and may not have a unique identification number of their own.
5.15	Member ID	The identifier assigned by the health plan to the patient who is insured by the health plan. When the patient is the actual member or health plan contract holder (the true subscriber) and not a dependent of the subscriber, it is the same as the Subscriber ID.
5.16	Relationship to Subscriber	Specifies only if patient is the subscriber or dependent within the context of the specified health plan.
5.17	Effective Date of Financial Responsibility	The begin date on which the Financial Responsibility Party became responsible for the payment of the patient's health care.
5.18	Financial Responsibility Party Address	The official mailing address of the Financial Responsibility Party to which written correspondence is to be directed.

Data Elem. ID	Data Element	Definition
5.19	Financial Responsibility Party Phone/Email/URL	A telephone number (voice or fax), e-mail address, or other locator for a resource mediated by telecommunication equipment. One object class is used to describe phone numbers, pagers, Email addresses, and URLs. One or more of these contact numbers can be designated as the preferred methods of contact; temporary items can be entered for use on specific effective dates.
5.20	Patient Name	The name of the actual patient who is a member or enrollee of health plan as entered into the eligibility system of the health plan. The patient may be the true subscriber or any related spouse, children, or dependent. See section 4.2.3.1.5.3
5.21	Patient Address	The mailing address of the patient who is a member or enrollee of health plan as recorded by the health plan. This address may be the same as or different from the true subscriber of the health plan. The mailing address used by the health plan may also differ from any other address otherwise used by the patient. See section 4.2.3.1.5.5
5.22	Patient Phone/Email/URL	A telephone number (voice or fax), e-mail address, or other locator for a resource mediated by telecommunication equipment. One object class is used to describe phone numbers, pagers, Email addresses, and URLs. One or more of these contact numbers can be designated as the preferred methods of contact; temporary items can be entered for use on specific effective dates. These contact numbers will be as specified in the CDA R2 correspondence for Telephone Numbers, E-Mail Addresses, and URLs reflected in the CCD Draft.
5.23	Patient Date of Birth	The date of birth of the patient as entered into the eligibility system of the health plan. See section 4.2.3.1.5.4
5.24	Financially Responsible Party Name	The name of the financially responsible party.

Table 4.2.3.1.5-1 Insurance Providers Data Element Definitions

4.2.3.1.5.1 Subscriber Name

For various reasons the health plan's eligibility system may not have the subscriber's legal given name and alternatively may know the subscriber by some other name, e.g., nickname, etc. Using the subscriber name as recorded by the eligibility system will improve the healthcare provider's ability to determine eligibility for benefits, and reduce rejections of claims.

4.2.3.1.5.2 Subscriber Date of Birth

For multiple and varied reasons, the health plan's eligibility system may not have the subscriber's actual date of birth. Using the subscriber date of birth as recorded by the eligibility system will improve the healthcare provider's ability to determine eligibility for benefits, and reduce rejections of claims.

4.2.3.1.5.3 Patient Name

For various reasons the health plan's eligibility system may not have the patient's legal given name and alternatively may know the patient by some other name, e.g., nickname, etc. Using the patient name as recorded by the eligibility system will improve the healthcare provider's ability to determine eligibility for benefits, and reduce rejections of claims.

4.2.3.1.5.4 Patient Date of Birth

For various reasons the health plan's eligibility system may not have the patient's actual date of birth. Using the date of birth as recorded by the eligibility system will improve the healthcare provider's ability to determine eligibility for benefits, and reduce rejections of claims.

4.2.3.1.5.5 Patient Address

For various reasons the health plan may use a different mailing address for the patient than the patient has on record elsewhere (e.g., as would be recorded in data element 1.03 Person Address above).

580

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
5.01	Health Plan Begin Date	R2/N	cda:participant[@typeCode='HLD']/ cda:time	None
5.02	Health Insurance Type	R2/N	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode= 'POLHOLD']/ cda:scopingOrganization/ cda:standardIndustryClassCode	Shall have a value drawn for the X12 Insurance Type Code
5.03	Financial Responsibilty Party Type	R/N	cda:participant/@typeCode	HLD = Policy Holder GUAR = Guarantor
5.04	Health Plan Insurance Information Source Name	R2/N	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode= 'POLHOLD']/ cda:scopingOrganization/cda:name	None
5.05	Health Plan Name	R2/N	pcc:sponsor/ cetc:sponsorPlan/ cetc:name	See section 4.2.3.1.5.7
5.06	Health Plan Insurance Information Source Address	O/Y	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode= 'POLHOLD']/ cda:scopingOrganization/cda:addr	None
5.07	Health Plan Insurance Information Source Phone/Email/URL	O/Y	cda:performer/ cda:assignedEntity/ cda:telecom	None
5.08	Health Plan Insurance Information Source ID	O/N	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode= 'POLHOLD']/ cda:scopingOrganization/cda:id	None

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
5.09	Subscriber Name	R/N	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode= 'POLHOLD']/ cda:associatedPerson/ cda:name	None
5.10	Subscriber Date of Birth	R/N	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode= 'POLHOLD']/cda:associatedPerson/ cetc:birthTime	See section 0
5.11	Subscriber Address	R/N	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode= 'POLHOLD']/ cda:addr	None
5.12	Subscriber Phone/Email/URL	R2/Y	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode= 'POLHOLD']/ cda:telecom	None
5.13	Group Number	O/N	cda:performer/cda:assignedEntity/p cc:sponsor/pcc:id	See section 4.2.3.1.5.9
5.14	Subscriber ID	R/N	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode= 'POLHOLD']/ cda:associatedPerson/cda:id	None
5.15	Member ID	R2/N	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode= 'POLHOLD']/ pcc:patient/pcc:id	See section 4.2.3.1.5.10
5.16	Relationship to Subscriber	R/N	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode= 'POLHOLD']/ cda:code	HL7 Relations mapped to X12 Y/N question.
5.17	Effective Date of Financial Responsibility	R2/N	cda:participant[not(@typeCode='HLD')]/cda:time	None

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
5.18	Financial Responsibility Party Address	R2/Y	cda:participant[@typeCode='GUAR']/cda:associatedEntity/ cda:addr	None
5.19	Financial Responsibility Party Phone/Email/URL	R2/Y	cda:participant[@typeCode='GUAR']/cda:associatedEntity/ cda:telecom	None
5.20	Patient Name	R/N	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity/ pcc:patient/cetc:patientAsKnown/ cetc:name	See section 4.2.3.1.5.10
5.21	Patient Address	R2/Y	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity[@classCode= 'POLHOLD']/ pcc:patient/cetc:addr	See section 4.2.3.1.5.10
5.22	Patient Phone/Email/URL	R2/Y	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity/ pcc:patient/cetc:telecom	See section 4.2.3.1.5.10
5.23	Patient Date of Birth	R/N	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity/pcc:patient/ cetc:patientAsKnown/ cetc:birthTime	See section 4.2.3.1.5.10
5.24	Financial Responsibility Party Name	R2/N	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity/ cda:associatedPerson/cda:name	None

Table 4.2.3.1.5-1 Insurance Providers Data Element Requirements

4.2.3.1.5.6 Use of Extensions to Support this Module

IHE XPHR defines an extension to the base standard in Appendix A.2 Group and Subscriber Identifiers. That extension describes how to represent Group Number and Member ID. This content component makes use of that extension.

During review and subsequent addition of several other data elements it was determined that the base and composite standards do not explicitly support the ability to describe Health Plan Name, or the Patient Name, Patient Address, Patient Phone/Email/URL and Patient Date of Birth Information to the base and composite standards.

This specification closes that gap by defining an extension to the composite standard that supports these data elements. The description of this extension appears as an HL7 Model in figure 4.2.3.1.5.6-1.

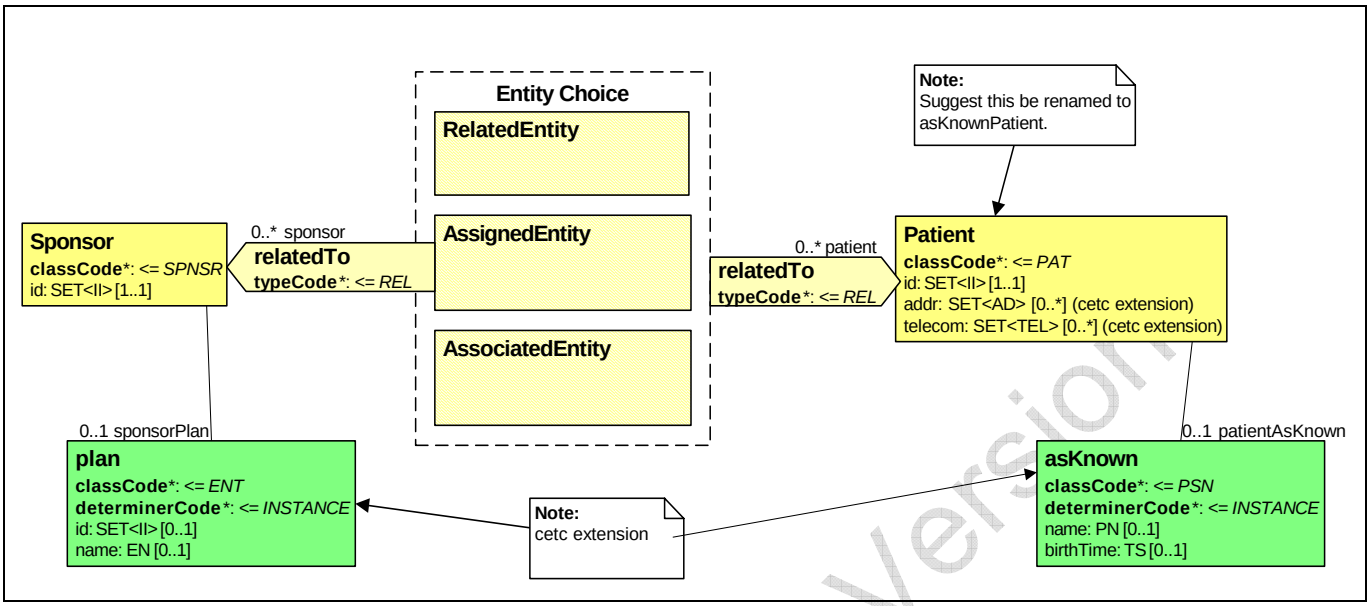

Figure 4.2.3.1.5.6-1 Extensions supporting the Insurance Providers Module

The plan object in this model supports recording of the plan name and identifier. The asKnown object in this model allows the patient's name, address, phone/Email/URL, and Date of Birth as known by the eligibility system to be recorded. The XML representations are described in more detail in the following sections.

4.2.3.1.5.7 Health Plan Name

The Health Plan Name is recorded as a <cetc:sponsorPlan> element inside the <pcc:sponsor> element. This element can record the plan name using the <cetc:name> element. The content of this element is a simple string that represents the name of the health plan.

```
<pcc:sponsor>
        <pcc:id root='' extension=''/>
        <cetc:sponsorPlan>
                <cetc:name>Good Health Plan</cetc:name>
        </cetc:sponsorPlan>
</pcc:sponsor>
```

Figure 4.2.3.1.5.7-1 Health Plan Name Example

4.2.3.1.5.8 Subscriber Date of Birth

The subscriber date of birth is represented using a <cetc:birthTime> element inside the <cda:assignedPerson> element. This is shown in the figure below.

```
<cda:assignedPerson>
        <cda:name>
                <cda:givenName>John</cda:givenName>
                <cda:familyName>Sample</cda:familyName>
        </cda:name>
        <cetc:birthTime value='19650120'/>
</cda:assignedPerson>
```

Figure 4.2.3.1.5.8-1 Subscriber Date of Birth Example

4.2.3.1.5.9 Group Number

The group number identifies the sponsor to the health plan with respect to the sponsored contract or policy. The <pcc:id> element in the <pcc:sponsor> element records this information. The extension attribute of the <pcc:id> element stores the group number. The root attribute records the OID of the assigning authority of that identifier.

```
<pcc:sponsor>
        <pcc:id root='' extension='67776520'/>
<pcc:sponsor>
```

Figure 4.2.3.1.5.9-1 Group Number Example

4.2.3.1.5.10 Member ID, Patient Name, Address, Phone/Email/URL and Date of Birth

These data elements identify the patient to the health plan for eligibility and/or claims processing. They are shown in the figure below.

```
<cda:associatedEntity classCode='POLHOLD'>
   <pcc:patient>
        <pcc:id root='' extension='91283746'/>
        <cetc:addr>
                <cetc:streetAddressLine>2930 South River Road</cetc:streetAddressLine>
                <cetc:city>Des Plaines</cetc:city><cetc:state>IL</cetc:state>
                <cetc:postalCode>60018</cetc:postalCode>
        </cetc:addr>
        <cetc:telecom value='tel:999-296-8900'/>
        <cetc:patientAsKnown>
                <cetc:name>
                        <cetc:givenName>John</cetc:givenName>
                        <cetc:familyName>Sample</cetc:familyName>
                </cetc:name>
                <cetc:birthTime value='19650120'/>
        </pcc:name>
    </pcc:patient>
</cda:associatedEntity>
```

Figure 4.2.3.1.5.10 - 1 Member ID, Patient Name, Address, Phone/Email/URL and Date of Birth Example

In the above example:

- The Member ID is recorded in the <pcc:id> element.
- The Patient Name is recorded in the <cetc:name> element.
- The Patient Address is recorded in the <cetc:addr> element.
- The Patient Phone number is recorded in the <cetc:telecom> element.
- The Date of Birth is recorded in the <cetc:birthTime> element.

675

4.2.3.1.6 Allergies and Drug Sensitivities Module

This module contains the allergy or intolerance conditions and the associated adverse reactions suffered by the patient. At a minimum, currently active and any relevant historical allergies and adverse reactions shall be listed. – Adapted from CCD

680

Data Elem. ID	Data Element	Definition
6.01	Allergy Date	This is a date that expresses when this particular allergy or intolerance was known to be active for the patient.
6.02	Allergy Type	Describes the type of product and intolerance suffered by the patient. The type of product shall be classified with respect to whether the allergy is to a medication, food, or environmental or other product. The intolerance should also be classified more specifically as an allergy, non-allergy intolerance, or just intolerance if that level of detail is not known.
6.03	Product Free-Text	This is the name or other description of the product or agent that causes the intolerance.
6.04	Reaction Free-Text	This is the reaction that may be caused by the product or agent.
6.05	Severity Free-Text	This is a description of the level of severity of the allergy or intolerance.
6.06	Product Coded	This value is a code describing the product.
6.07	Reaction Coded	This value is a code describing the reaction.
6.08	Severity Coded	This value is a code describing the level severity of the allergy or intolerance.

Table 4.2.3.1.6-1 – Allergies and Drug Sensitivities Data Element Definitions

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
6.01	Allergy Date	R2/Y	cda:observation/cda:effectiveTime	None
6.02	Allergy Type	R	cda:observation/cda:code	See 4.2.3.1.6.1
6.03	Product Free-Text	R	cda:observation/ cda:participant[@typeCode='CSM']/ cda:participantRole[@classCode='MANU']/ cda:playingEntity[@classCode='MMAT']/cda:code/ cda:originalText	None
6.04	Reaction Free-Text	R2	cda:observation/ cda:entryRelationship[@typeCode='MFST'] / cda:observation/cda:value/cda:originalText/ cda:reference/@value	None
6.05	Severity Free-Text	R2	cda:observation/ cda:entryRelationship[@typeCode='SUBJ']/ cda:observation/cda:code[@code='SEV']/ cda:value/cda:originalText/cda:reference/@value	None
6.06	Product Coded	R2	cda:observation/ cda:participant[@typeCode='CSM']/ cda:participantRole[@classCode='MANU']/ cda:playingEntity[@classCode='MMAT']/ cda:code	See 4.2.3.1.6.2
6.07	Reaction Coded	R2	cda:observation/ cda:entryRelationship[@typeCode='MFST'] / cda:observation/cda:value	See 4.2.3.1.6.3
6.08	Severity Coded	R2	cda:observation/ cda:entryRelationship[@typeCode='SUBJ']/ cda:observation/cda:code[@code='SEV']/ cda:value	See 4.2.3.1.6.4

685 Table 4.2.3.1.6-1 – Allergies and Drug Sensitivities Data Element Requirements

4.2.3.1.6.1 Allergy Type Vocabulary

The vocabulary used for allergy types is derived from a limited set of values SNOMED CT. The OID for this terminology is 2.16.840.1.113883.6.96.

690

SNOMED CT Preferred Terms for Allergy Type	SNOMED CT Code
propensity to adverse reactions	420134006
propensity to adverse reactions to substance	418038007
allergy to substance	419199007
drug allergy	416098002
food allergy	414285001
propensity to adverse reactions to drug	419511003
drug allergy	416098002
drug intolerance	59037007

propensity to adverse reactions to food	418471000
food intolerance	235719002
food allergy	414285001

Table 4.2.3.1.6.1-1 Allergy Type Vocabulary

4.2.3.1.6.2 Product Coded Vocabulary

The product causing the allergy shall be coded to UNII for Food and substance allergies, or RX-Norm when to brand name drugs.

4.2.3.1.6.3 Reaction Coded

The reaction shall be coded using SNOMED CT, and shall be terms that descend from the clinical finding (404684003) concept.

4.2.3.1.6.4 Severity Coded

The terminology used for severity of severity of allergy or intolerance shall be coded to SNOMED CT, and shall be terms that descend from the severities (272141005) concept.

4.2.3.1.7 Conditions Module

This module lists and describes all relevant clinical problems at the time the summary is generated. At a minimum, all pertinent current and historical problems should be listed. – Adapted from CCD

A registration summary is normally limited to a brief list of serious major medical conditions that should always be disclosed even in many ancillary service department settings. Because there is a difference between a full problem list and a brief check list of major conditions, it should be easy for the provider to know that this is a brief registration summary list.

Data Elem. ID	Data Element	Definition
7.01	Problem Date	This is the range of time of which the problem was active for the patient.
7.02	Problem Type	This is a fixed value indicating the level of medical judgment used to determine the existence of a problem.
7.03	Problem Name	This is a text description of the problem suffered.
7.04	Problem Code	This value is a code describing the problem according to a specific vocabulary of problems.

Table 4.2.3.1.7-1 Conditions Data Element Definitions

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
7.01	Problem Date	R2	cda:observation/cda:effectiveTime	None
7.02	Problem Type	R2	cda:observation/cda:code	None
7.03	Problem Name	R	cda:observation/cda:value/cda:originalText/ cda:reference/@value	None
7.04	Problem Code	O	cda:observation/cda:value	Veterans Health Administration/Kaiser Permanente Problem List Subset of SNOMED (mapped to ICD-9-CM) See 4.2.3.1.7.1

Table 4.2.3.1.7-2 Conditions Data Element Requirements

4.2.3.1.7.1 Problem Code

The problem shall be coded using the VA/KP Problem List Subset of SNOMED CT, and shall be terms that descend from the clinical finding (404684003) concept.

4.2.3.1.8 Medications – Prescription and Non-Prescription Module

This module defines a patient's current medications and pertinent medication history. At a minimum, the currently active medications should be listed. – Adapted from CCD

Data Elem. ID	Data Element	Definition
8.01	Order Date/Time	The date, including time if available, when the prescriber wrote the order
8.02	Type of Medication	A classification based on how the medication is marketed (e.g., prescription, over the counter drug).
8.03	Free Text Product Name	The name of the substance or product. If a Coded Product Name is present, this is the text associated with the coded concept. This should be sufficient for a provider to identify the kind of medication. If the name of the product is unknown, the type, purpose or other description may be supplied.
8.04	Coded Product Name	A code describing the product from a controlled vocabulary (e.g., RxNorm, NDC)
8.05	Free Text Brand Name	The branded or trademarked name of the substance or product. If a Coded Brand Name is present, this is the text assoicated with the coded concept.
8.06	Coded Brand Name	A code describing the product as a branded or trademarked entity from a controlled vocabulary (e.g., RxNorm, NDC)
8.07	Status of Medication	If the medication Active, D/C'd, Chronic, Acute, etc.
8.08	Drug Manufacturer	The manufacturer of the substance or product as ordered. The distributor may be supplied if the manufacturer is not known.
8.09	Product Form	The physical form of the product as presented to the patient. For example: tablet, capsule, liquid, ointment.
8.10	Product Concentration	The amount of active ingredient, or substance of interest, in a specified product dosage unit, mass or volume. For example 250 mg per 5 ml. Note: "product dosage unit" provides for describing the "concentration" of a physical form. For example, 800 mg per 1 tablet. In this manner, this data element may also be known as Product Strength. This may be implicit in the product as named or as a codified product.
8.11	Quantity Ordered	The amount of product indicated by the prescriber to be dispensed. For example, number of dosage units or volume of a liquid substance. Note that this is comprised of both a numeric value and a unit of measure.
8.12	Free Text Sig	The instructions, typically from the prescriber, to the patient on the proper means and timing for the use of the product. This information is free-text but can also be prepresented as a series of SIG components.
8.13	Dose Indicator	A SIG component: A criteria that specifies when an action is, or is not, to be taken. For example, "if blood sugar is above 250 mg/dl".
8.14	Delivery Method	A SIG component: A description of how the product is administered/consumed. For example, orally, topically, subcutaneous injection.
8.15	Dose	A SIG component: the amount of the product to be given. This may be a known, measurable unit (e.g., milliliters), an administration unit (e.g., tablet), or an amount of active ingredient (e.g., 250 mg). May define a variable dose, dose range or dose options based upon identified criteria (see Dose Indicator).
8.16	Vehicle	A SIG component: Non-active ingredient(s), or substances not of therapeutic interest, in which the active ingredients are dispersed. Most often applied to liquid products where the major fluid component is considered the vehicle. For example: Normal Saline is the vehicle in "Ampicllin 150mg in 50ml NS"; Aquaphor is the vehicle in "10% LCD in Aquaphor".
8.17	Route	A SIG component: indicates how the medication is received by the patient (e.g., by mouth, intravenously, topically, et cetera).
8.18	Site	A SIG component: The anatomic site where the medication is administered. Usually applicable to injected or topical products
8.19	Administration Timing	A SIG component: defines a specific administration or use time. Can be a text string (Morning, Evening, Before Meals, 1 Hour After Meals, 3 Hours After Meals, Before Bed) or an exact time.

Data Elem. ID	Data Element	Definition
8.20	Frequency	A SIG component: defines how often the medication is to be administered as events per unit of time. Often expressed as the number of times per day (e.g., four times a day), but may also include event-related information (e.g., 1 hour before meals, in the morning, at bedtime). Complimentary to Interval, although equivalent expressions may have different implications (e.g., every 8 hours versus 3 times a day).
8.21	Interval	A SIG component: defines how the product is to be administered as as interval of time. For example, every 8 hours. Complimentary to Frequency, although equivalent expressions may have different implications (e.g., every 8 hours versus 3 times a day).
8.22	Duration	A SIG component: for non-instantaneous administrations, indicates the length of time the administration should be continued. For example, (infuse) over 30 minutes.
8.23	Dose Restriction	A SIG component: defines a maximum or dose limit. This segment can repeat for more than one dose restriction.
8.24	Indication	A SIG component: The medical condition or problem intended to be addressed by the ordered product. For example: for chest pain, for pain, for high blood pressure.
8.25	Indicate Medication Stopped	A SIG component: Used to express a "hard stop", such as the last SIG sequence in a tapering dose, where the last sequence is 'then D/C' or where the therapy/drug is used to treat a condition and that treatment is for a fixed duration with a hard stop, such as antibiotic treatment, etc.
8.26	Patient Instructions	Instructions to the patient that are not traditionally part of the SIG. For example, "keep in the refrigerator".
8.27	Fullfillment Instructions	Instructions to the dispensing pharmacist or nurse that are not traditionally part of the SIG. For example, "instruct patient on the use of occlusive dressing".
8.28	Refills	The number of times that the prescriber has authorized the pharmacy to dispense this medication.
8.29	Reaction	Any noted intended or unintended effects of the product. For example: full body rash, nausea, rash resolved.
8.30	Fulfillment History	History of dispenses for this order. Comprised of Fulfillment History components.
8.31	Provider	Fulfillment History component: The pharmacy that performed this dispense (may include both a name and an identifier)
8.32	Location	Fulfillment History component: The pharmacy's location
8.33	Dispense Date	Fulfillment History component: The date of this dispense
8.34	Quantity Dispensed	Fulfillment History component: The actual quantity of product supplied in this dispense
8.35	Prescription Number	Fulfillment History component: The prescription identifier assigned by the pharmacy.
8.36	Source of the Medication Information	Informant of this information, who is responsible for this information regarding this order and the related dispense event(s).
8.37	Ordering Provider	The person that wrote this order (may include both a name and an identifier)

Table 4.2.3.1.8-1 Medications – Prescription and Non-Prescription Data Element Definitions

730

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
8.01	Order Date/Time	O/N	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:time	None
8.02	Type of Medication	R2/N	cda:substanceAdministration/ cda:consumable/ cda:manufacturedProduct/ cda:manufacturedLabeledDrug/ cda:code/cda:translation	Shall have a value drawn from the SPL Content of Labeling Type (e.g., prescription drug, Over the Counter) - source LOINC.
8.03	Free Text Product Name	R/N	cda:substanceAdministration/ cda:consumable/ cda:manufacturedProduct/ cda:manufacturedLabeledDrug/ cda:name	None
8.04	Coded Product Name	R2/Y	cda:substanceAdministration/ cda:consumable/cda:manufacturedProduct/ cda:manufacturedLabeledDrug/ cda:code	Shall have value drawn from RxNorm (Brand name (e.g., Tylenol)) , UNII (Generic name (e.g., acetaminophen)), NDC (packaged product (e.g., Tylenol 325 mg tablet), RxNorm (clinical drug (e.g. acetaminophen 325 mg tablet))
8.05	Free Text Brand Name	R2/N	cda:substanceAdministration/ cda:consumable/ cda:manufacturedProduct/ cda:manufacturedLabeledDrug/ cda:name	None
8.06	Coded Brand Name	R2/Y	cda:substanceAdministration/ cda:consumable/ cda:manufacturedProduct/ cda:manufacturedLabeledDrug/ cda:code	Shall have value drawn from RxNorm BrandCode
8.07	Status of Medication	R2/N	cda:substanceAdministration/cda:entryRelationship/ cda:observation/cda:code[@code='CLINSTATUS' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	None
8.08	Drug Manufacturer	O/N	cda:substanceAdministration/ cda:consumable/ cda:manufacturedProduct/ cda:manufacturerOrganization/	Manufacturer or distributor - Shall have a value drawn from Labeler code - FDA labeler code - source NDC
8.09	Product Form	O/N	cda:substanceAdministration/ cda:administrationUnitCode	Shall have a value drawn from dosage form - FDA dosage form – source NCI Thesaurus
8.10	Product Concentration	R2/N	See comment in HITSP Additional Specifications section for this data element	Product concentration may be implicit in coded product name/coded brand name. For a preparation, the details of the preparation can be specified in subordinate substance administration entries Shall have a value drawn from unit of measure - FDA potency - source NCI Thesaurus and Unified Code for Units of Measures
8.11	Quantity Ordered	R2/N	cda:supply/cda:quantity	Shall have a value (e.g., tablet) drawn from units of measure – FDA potency – source NCI Thesaurus and Unified Code for Units and Measures

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
8.12	Free Text Sig	O/N	cda:substanceAdministration/ cda:text	None
8.13	Dose Indicator	O/Y	cda:substanceAdministration/ cda:precondition/cda:criteria	None
8.14	Delivery Method	O/Y	cda:substanceAdministration/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	None
8.15	Dose	O/Y	cda:substanceAdministration/ cda:doseQuantity	Shall have a value drawn from FDA potency - source NCI Thesaurus and Unified Code for Units of Measure
8.16	Vehicle	O/Y	cda:substanceAdministration/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	Same as product or brand
8.17	Route	O/Y	cda:substanceAdministration/ cda:routeCode	Shall have a value drawn from FDA route of administration - source NCI Thesaurus
8.18	Site	O/Y	cda:substanceAdministration/ cda:approachSiteCode	None
8.19	Administration Timing	O/Y	cda:substanceAdministration/ cda:effectiveTime[2]	None
8.20	Frequency	O/Y	cda:substanceAdministration/ cda:effectiveTime[2]	None
8.21	Interval	O/Y	cda:substanceAdministration/ cda:effectiveTime[2]	None
8.22	Duration	O/Y	cda:substanceAdministration/ cda:effectiveTime[2]	None
8.23	Dose Restriction	O/Y	cda:substanceAdministration/ cda:maxDoseQuantity	None
8.24	Indication	O/Y	cda:substanceAdministration/ cda:entryRelationship[@typeCode='RSON']/cda:observation	Veterans Health Administration/Kaiser Permanente Problem List Subset of SNOMED See 4.2.3.1.7.1
8.25	Indicate Medication Stopped	O/N	cda:substanceAdministration/ cda:effectiveTime[1]/cda:high	None
8.26	Patient Instructions	O/N	cda:substanceAdministration/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	None
8.27	Fullfillment Instructions	O/N	cda:supply/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	None
8.28	Refills	O/N	cda:supply/cda:repeatNumber	None
8.29	Reaction	O/N		Reaction tracking is profiled within the XDS-MS and XPHR profiles through recording of Allergies and Intolerances.
8.30	Fulfillment History	O/Y	cda:supply/cda:repeatNumber	None

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
8.31	Provider	O/N	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:assignedAuthor/ cda:assignedPerson	None
8.32	Location	O/N	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:assignedAuthor/ cda:representedOrganization	None
8.33	Dispense Date	O/N	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:assignedAuthor/ cda:representedOrganization	None
8.34	Quantity Dispensed	R2/N	cda:supply/cda:quantity	Shall have a value (e.g., tablet) drawn from– FDA potency – source NCI Thesaurus and Unified Code for Units of Measure
8.35	Prescription Number	R2/N	cda:supply/cda:id	None
8.36	Source of the Medication Information	R2/N	cda:substanceAdministration/ ancestor-or-self::cda:informant	None
8.37	Ordering Provider	O/N	TBD	TBD

Table 4.2.3.1.8-2 - Medications – Prescription and Non-Prescription Data Element Requirements

735

4.2.3.1.8.1 Indication

The indication shall be coded using the VA/KP Problem List Subset of SNOMED CT, and shall be terms that descend from the clinical finding (404684003) concept.

740 ### 4.2.3.1.9 Pregnancy Module

This module contains coded entries describing the patient history of pregnancies.
Adapted from XPHR.

745

Data Elem. ID	Data Element	Definition
9.01	Pregnancy	This is a simple observation that records whether the patient is currently pregnant.

Table 4.2.3.1.9-1 – Pregnancy Data Element Definitions

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
9.01	Pregnancy		cda:observation[cda:code[@code='11 449-6' and @codeSystem='2.16.840.1.113883.1']]/cda:value	Use the SNOMED-CT code for patient currently pregnant (77386006)

Table 4.2.3.1.9-2 Pregnancy Data Element Requirements

4.2.3.1.10 Information Source Module

This module allows for information about the original author to be supplied and for a reference to the original document to be provided. This module may be applied to other modules 4.2.3.1.1 through 4.2.3.1.9

Data Elem. ID	Data Element	Definition
10.00	Author	The author of the information content.
10.01	Author Name	The name person who created the information content.
10.02	Author Time	The time at which this information was created.
10.03	Reference	A reference to the original document from which this information was obtained.
10.04	Reference Document ID	Identifier of the external document that was referenced.
10.05	Reference Document URL	A URL from which this document may be retrieved. *Note, I believe we only allow references to documents which have been registered, so as to ensure that the registry / repository / PHR access control mechanisms are used to access these documents.*

Table 4.2.3.1.10-1 Information Source Data Element Definitions

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
10.00	Author	R2/N	cda:author	None
10.01	Author Name	R/N	cda:author/cda:assignedAuthor/ cda:name	None
10.02	Author Time	R/N	cdc:author/cda:time	None
10.03	Reference	R2/Y	cda:reference/cda:externalDocument	None
10.04	Reference Document ID	R/N	cda:reference/cda:externalDocument/ cda:id	None
10.05	Reference Document URL	O/N	cda:reference/cda:externalDocument/ cda:text/cda:reference/@value	None

Table 4.2.3.1.10-2 Information Source Data Element Requirements

Notes:

Each content module described above in subsection 6-9 and 12 may have one author. The author is the person who created the information content. The <author> element may be included in the

<observation>, <substanceAdministration> or <supply> element hosting the information described in the content modules defined above to indicate who created this information and when it was created.
Each content module described above in subsection 6-9 and 12 may have one <reference> element that describes the document that was the original source of the information. The <reference> element may be included in the <observation>, <substanceAdministration> or <supply> element hosting the information described in the content modules defined above to indicate what document the information came from.

4.2.3.1.11 Comments Module

This module allows for a comment to be supplied for any other module listed in subsections 1-9 above.

Data Elem. ID	Data Element	Definition
11.01	Commenter	The creator of the comment.
11.02	Comment Date	The date and time the comment was provided.
11.03	Free Text Comment	A free text comment.

Table 4.2.3.1.11-1 Comments Data Element Definitions

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
11.01	Commenter	R2/Y	cda:author/cda:name	None
11.02	Comment Date	R/N	cda:author/cda:time	None
11.03	Free Text Comment	R/N	cda:text/cda:reference/@value	None

Table 4.2.3.1.11-2 Comments Data Element Requirements

Notes:
Each content module described above in subsection 6-9 and 12 may have one or more comments made upon it. This module uses the structure for comments defined in the IHE PCC Technical Framework Volume 2, section 5.4.4.5.2, relaxing the constraint that only one comment may be present.

4.2.3.1.12 Advance Directives

This module contains data describing the patient's advance directives and any reference to supporting documentation. This section contains data such as the existence of living wills, healthcare proxies, and CPR and resuscitation status. The custodian of these documents may be described.
-Adapted from CCD

Data Elem. ID	Data Element	Definition
12.01	Effective Date	The effective date for the advance directive.
12.02	Advance Directive Type	This is a coded value describing the type of the advance directive.
12.03	Custodian of the Document	Name, address or other contact information for the person or organization that can provide a copy of the document.

Table 4.2.3.1.12-1 Advance Directives Data Element Definitions

795

Data Elem. ID	Data Element	HITSP Opt / Repeat	CCD/XPHR Name	HITSP Additonal Specification for Reg/Med Component
12.01	Effective Date	R/N	cda:act/ cda:effectiveTime	None
12.02	Advance Directive Coded Type	R2/N	cda:act/cda:code	*Vocabulary needed, this is a gap*
12.03	Custodian of the Document	O/N	cda:act/cda:participant[@typeCode=' CST']	*This is at variance with CCD, but allows the custodian to be represented.*
12.04	Advance Directive Free Text Type	R/N	cda:act/cda:code/cda:originalText/ cda:reference/@value	None

Table 4.2.3.1.11-1 Comments Data Element Requirements

5.0 CONSTRAINTS FOR REUSE

800 There are no constraints regarding use or reuse of this component. It is intended for use and reuse whenever a consumer's patient registration and medical history information is needed.

6.0 APPENDIX

This appendix provides additional detail not included in the other parts of the specification, but that are
805 supportive of the specification. It also provides example mappings into this component specification. Three mappings of the Registration/Medication History Document Component elements are provided at this time, namely to NCPDP Script 8.1 element names, X12N 271 element names and ASTM E2369-5 CCR element names. A mapping of these same elements to HL7 v2.x segments and elements is not currently included but may be provided in a future version of this Component document.

810

6.1 GLOSSARY

The HITSP glossary that spans all the Interoperability Specifications can be found in the following folder on the HITSP site:
http://publicaa.ansi.org/sites/apdl/Documents/Forms/AllItems.aspx?RootFolder=http%3a%2f%2fpublicaa
815 %2eansi%2eorg%2fsites%2fapdl%2fDocuments%2fStandards%20Activities%2fHealthcare%20Informatic
s%20Technology%20Standards%20Panel

6.2 MAPPING OF NCPDP MEDICATION ATTRIBUTES INTO THE REG/MED HISTORY COMPONENT

This section illustrates a mapping of the NCPDP Script 8.1 standard into the Medications – Prescription and Non-Prescription Module of the Reg/Med History Component[2]. This is informative text only and is not a normative part of this document.

The *XML Companion Guide* for NCPDP *SCRIPT* provides details and guidelines for developers to exchange electronic prescription messages utilizing an XML implementation of NCPDP *SCRIPT*. The document describes the XML Message standard, the set of supported messages, and other variables related to the use of an XML implementation of *SCRIPT*. The XML Message standard supports the same featured message sets as EDIFACT implementations of NCPDP *SCRIPT* a one-to-one correspondence for their respective data elements.

6.2.1 MEDICATIONS – PRESCRIPTION AND NON-PRESCRIPTION MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	NCPDP Name
8.01	Order Date/Time	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:time	DRU Ø4Ø-IØØ6 Date Composite (Qualifier, Date, Format) SCRIPT value 85 = Date Issued (Written Date) for original order date. CCYYMMDD
8.02	Type of Medication	cda:substanceAdministration/ cda:consumable/ cda:manufacturedProduct/ cda:manufacturedLabeledDrug/ cda:code/cda:translation	Not Used
8.03	Free Text Product Name	cda:substanceAdministration/ cda:consumable/cda:manufacturedProduct/ cda:manufacturedLabeledDrug/cda:name	DRU Ø1Ø-IØ13-Ø2-7ØØ8, Ø1Ø-IØ13-1Ø-7ØØ8, Ø1Ø-IØ13-11-7ØØ8, Ø1Ø-IØ13-12-7ØØ8 Item Description
8.04	Coded Product Name	cda:substanceAdministration/ cda:consumable/cda:manufacturedProduct/ cda:manufacturedLabeledDrug/cda:code	DRU Ø1Ø-IØ13-Ø3-714Ø Drug Number, Ø1Ø-IØ13-Ø4-3Ø55 Code List Responsibility Agency
8.05	Free Text Brand Name	cda:substanceAdministration/ cda:consumable/cda:manufacturedProduct/ cda:manufacturedLabeledDrug/cda:name	Not Used
8.06	Coded Brand Name	cda:substanceAdministration/ cda:consumable/cda:manufacturedProduct/ cda:manufacturedLabeledDrug/cda:code	Not Used

[2] Other modules do not map to NCPDP.

Data Elem. ID	Data Element	CCD/XPHR Name	NCPDP Name
8.07	Status of Medication	cda:substanceAdministration/ cda:entryRelationship/ cda:observation/cda:code[@code='CLINSTATUS' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	Not Used
8.08	Drug Manufacturer	cda:substanceAdministration/ cda:consumable/cda:manufacturedProduct/ cda:manufacturerOrganization/	Not Used
8.09	Product Form	cda:substanceAdministration/ cda:administrationUnitCode	DRU Ø1Ø-IØ13-Ø5-1131 Code List Qualifier Drug form, in a code.
8.10	Product Concentration		
8.11	Quantity Ordered	cda:supply/cda:quantity	DRU Ø2Ø-IØØ9 Quantity Composite (Ø2Ø-IØØ9-Ø1-6Ø63 Quantity Qualifier - Unit of Measure X-12 DE 355. Ø2Ø-IØØ9-Ø2-6Ø6Ø Quantity. Ø2Ø-IØØ9-Ø3-1131 Code List Qualifier (38 = Original Quantity))
8.12	Free Text Sig	cda:substanceAdministration/ cda:text	DRU Ø3Ø-IØ14-Ø2, -Ø3 Dosage (SIG instructions. Dosage free text.)
8.13	Dose Indicator	cda:substanceAdministration/ cda:precondition/cda:criteria	Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots.SIG Ø2Ø-Ø1 Dose Indicator
8.14	Delivery Method	cda:substanceAdministration/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots.SIG Ø2Ø-Ø2 Dose Delivery Method (Text, Code, Version, and System)
8.15	Dose	cda:substanceAdministration/ cda:doseQuantity	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG Ø2Ø-1Ø Dose as text. Can also express Dose Units Text, Code, Code System, Code System Version.
8.16	Vehicle	cda:substanceAdministration/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG Ø4Ø Vehicle (Name, Name Code, Name Code System, Name Code System Version). Also Vehicle Volume, Multiple Vehicle Modifier.
8.17	Route	cda:substanceAdministration/ cda:routeCode	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG Ø5Ø Route (Route, Code, System, Version, Multiple Modifier).

Data Elem. ID	Data Element	CCD/XPHR Name	NCPDP Name
8.18	Site	cda:substanceAdministration/ cda:approachSiteCode	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG Ø6Ø Site (Site, Code, System, Version, Multiple Modifier).
8.19	Administration Timing	cda:substanceAdministration/ cda:effectiveTime[2]	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG Ø8Ø Administration Timing (Text, Code, System, Version, Multiple Modifier).
8.20	Frequency	cda:substanceAdministration/ cda:effectiveTime[2]	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG Ø7Ø Frequency (Frequency, Units, Code, System, Version, Multiple Modifier).
8.21	Interval	cda:substanceAdministration/ cda:effectiveTime[2]	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG Ø9Ø Interval (Value, Text, Code, System, Version, Variable Interval Modifier).
8.22	Duration	cda:substanceAdministration/ cda:effectiveTime[2]	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG Ø9Ø Interval (Value, Text, Code, System, Version, Variable Interval Modifier).
8.23	Dose Restriction	cda:substanceAdministration/ cda:maxDoseQuantity	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG 11Ø Dose Restriction (Maximum Value, Units Text, Code, System, Version, Maximum Variable Value, Units Text, Code, System, Version, Maximum Calculation Equation Code, System, Version, Modifier).
8.24	Indication	cda:substanceAdministration/ cda:entryRelationship[@typeCode='RSON']/cda:observation	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG 12Ø Indication (Timing Text, Code, System, Version, Text, Code, System, Version, Value, Value Units, Code, System, Version, Modifier).

Data Elem. ID	Data Element	CCD/XPHR Name	NCPDP Name
8.25	Indicate Medication Stopped	cda:substanceAdministration/ cda:effectiveTime[1]/cda:high	Not Currently Mapped Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG 13Ø Stop (Indicator, Text, Code, System, Version).
8.26	Patient Instructions	cda:substanceAdministration/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG 14Ø Free Text
8.27	Fullfillment Instructions	cda:supply/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	Sig fields will be available in new Sig Segment in future version of SCRIPT after eprescribing pilots. SIG 14Ø Free Text
8.28	Refills	cda:supply/cda:repeatNumber	DRU - If number of Refills - Ø6Ø-IØØ9 Quantity Composite (Ø6Ø-IØØ9-Ø1-6Ø63 Quantity Qualifier (R = Number of Refills), Ø6Ø-IØØ9-Ø2-6Ø6Ø Quantity)
8.29	Reaction	TBD	DRU - Drug Use Evaluation (DUE) fields are available for explanation, conflict, or clarification of services related to drug use evaluation.
8.30	Fulfillment History	cda:supply/cda:repeatNumber	Loops of PVD (Prescriber), PVD (Pharmacy) and DRU (Drug) Segments to relay up to 300 history occurrences, within Medication History Response.
8.31	Provider	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:assignedAuthor/ cda:assignedPerson	Loops of PVD (Prescriber), PVD (Pharmacy) and DRU (Drug) Segments to relay up to 300 history occurrences, within Medication History Response.
8.32	Location	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:assignedAuthor/ cda:representedOrganization	If provider location, contained in PVD Segment, within Medication History Response.
8.33	Dispense Date	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:assignedAuthor/ cda:representedOrganization	DRU Ø4Ø-IØØ6 Date Composite (Qualifier, Date, Format) SCRIPT value LD = Last Demand (Last Fill) for original order date. CCYYMMDD. Within Medication History Response.
8.34	Quantity Dispensed	cda:supply/cda:quantity	DRU Ø2Ø-IØØ9 Quantity Composite (Ø2Ø-IØØ9-Ø1-6Ø63 Quantity Qualifier - Unit of Measure X-12 DE 355. Ø2Ø-IØØ9-Ø2-6Ø6Ø Quantity. Ø2Ø-IØØ9-Ø3-1131 Code List Qualifier (38 = Original Quantity)) within Medication History Response.
8.35	Prescription Number	cda:supply/cda:id/@extension	Not Used
8.36	Source of the Medication Information	cda:substanceAdministration/ ancestor-or-self::cda:informant	DRU Ø1Ø-IØ13-Ø3-714Ø Drug Number, Ø1Ø-IØ13-Ø4-3Ø55 Code List Responsibility Agency
8.37	Ordering Provider	TBD	TBD

835 Table 6.3.8-1 Medications – Prescription and Non-Prescription Data Element Mappings

6.3 MAPPING OF X12 PATIENT REGISTRATION ATTRIBUTES INTO THE REG/MED HISTORY COMPONENT

This section illustrates a mapping of the X12N 271 standard into the Insurance Providers Module of the Reg/Med History Component. This is informative text only and is not a normative part of this document.

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6.3.1 INSURANCE PROVIDERS MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	X12N 271 Name
5.01	Health Plan Begin Date	cda:participant[@typeCode='HLD']/ cda:time	DTP Segment/Loop 2100C/D
5.02	Health Insurance Type	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POL HOLD']/ cda:scopingOrganization/ cda:standardIndustryClassCode	EB04/Loop 2100C/D
5.03	Financial Responsibilty Party Type	cda:participant/@typeCode	Not Used
5.04	Health Plan Insurance Information Source Name	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POL HOLD']/ cda:scopingOrganization/cda:name	NM1 Segment/Loop 2100A
5.05	Health Plan Name	pcc:sponsor/ cetc:sponsorPlan/ cetc:name	EB05/Loop 2100C/D
5.06	Health Plan Insurance Information Source Address	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POL HOLD']/ cda:scopingOrganization/cda:addr	Not Used
5.07	Health Plan Insurance Information Source Phone/Email/URL	cda:performer/cda:assignedEntity/ cda:telecom	PER Segment/Loop 2100A
5.08	Health Plan Insurance Information Source ID	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POL HOLD']/ cda:scopingOrganization/cda:id	NM109/Loop 2100A
5.09	Subscriber Name	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POL HOLD']/ cda:associatedPerson/cda:name	NM103-04-05/Loop 2100C
5.10	Subscriber Date of Birth	cda:participant[@typeCode='HLD']/cda:associatedEntity[@classCode='POLHOLD']/cda:associatedPerson/cetc:birthTime	DMG Segment/Loop 2100C
5.11	Subscriber Address	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POL HOLD']/ cda:addr	N3/N4 Segments/Loop 2100C
5.12	Subscriber Phone/Email/URL	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POL HOLD']/ cda:telecom	PER Segment/Loop 2100C
5.13	Group Number	cda:performer/cda:assignedEntity/pcc:sponsor/pcc:id	EB04/Loop 2100C/D
5.14	Subscriber ID	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POL HOLD']/ cda:associatedPerson/cda:id	NM109/Loop 2100C
5.15	Member ID	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POL HOLD']/ pcc:patient/pcc:id	NM109/Loop 2100D

Data Elem. ID	Data Element	CCD/XPHR Name	X12N 271 Name
5.16	Relationship to Subscriber	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POL HOLD']/ cda:code	INS Segment/Loop 2100C
5.17	Effective Date of Financial Responsibility	cda:participant[@typeCode='GUAR']/cda:time	Not used
5.18	Financial Responsibility Party Address	cda:participant[@typeCode='GUAR']/cda:associatedEntity/ cda:addr	Not used
5.19	Financial Responsibility Party Phone/Email/URL	cda:participant[@typeCode='GUAR']/cda:associatedEntity/ cda:telecom	Not used
5.20	Patient Name	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity/ pcc:patient/cetc:patientAsKnown/ cetc:name	NM103-04-05/Loop 2100D
5.21	Patient Address	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity[@classCode='POL HOLD']/ pcc:patient/cetc:addr	N3/N4 Segments/Loop 2100D
5.22	Patient Phone/Email/URL	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity/ pcc:patient/cetc:telecom	PER Segment/Loop 2100D
5.23	Patient Date of Birth	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity/pcc:patient/ cetc:patientAsKnown/ cetc:birthTime	DMG Segment/Loop 2100D
5.24	Financially Responsible Party Name	cda:participant[@typeCode='GUAR']/ cda:associatedEntity/ cda:associatedPerson/cda:name	Not used

Table 6.4.5-1 Insurance Providers Module

6.4 MAPPING OF ASTM E2369 CCR ATTRIBUTES INTO THE REG/MED HISTORY COMPONENT

This section illustrates a mapping of the ASTM 2367 CCR standard into the Reg/Med History Component. This is informative text only and is not a normative part of this document.

6.4.1 PERSON INFORMATION MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
1.01	Document Timestamp	/cda:ClinicalDocument/cda:time	/ContinuityOfCareRecord/DateTime
1.02	Person Name	cda:recordTarget/cda:patientRole/ cda:patient/cda:name	/ContinuityOfCareRecord/Actors/Actor/Person/Name[ActorObjectID = /ContinuityOfCareRecord/Patient/ActorID]
1.03	Person Address	cda:recordTarget/cda:patientRole/ cda:addr	/ContinuityOfCareRecord/Actors/Actor/Address[ActorObjectID = /ContinuityOfCareRecord/Patient/ActorID]
1.04	Person Phone/Email/URL	cda:recordTarget/cda:patientRole/ cda:telecom	/ContinuityOfCareRecord/Actors/Actor/Telephone[ActorObjectID = ContinuityOfCareRecord/Patient/ActorID] /ContinuityOfCareRecord/Actors/Actor/EMail[ActorObjectID = /ContinuityOfCareRecord/Patient/ActorID] /ContinuityOfCareRecord/Actors/Actor/URL[ActorObjectID = /ContinuityOfCareRecord/Patient/ActorID]
1.05	Person ID	cda:recordTarget/cda:patientRole/ cda:id	/ContinuityOfCareRecord/Actors/Actor/IDs[Actor ObjectID = /ContinuityOfCareRecord/Patient/ActorID]
1.06	Person Date of Birth	cda:recordTarget/cda:patientRole/ cda:patient/cda:birthTime	/ContinuityOfCareRecord/Actors/Actor/Person/DateOfBirth[ActorObjectID = /ContinuityOfCareRecord/Patient/ActorID]
1.07	Gender	cda:recordTarget/cda:patientRole/ cda:patient/ cda:administrativeGenderCode	/ContinuityOfCareRecord/Actors/Actor/Person/Gender[ActorObjectID = /ContinuityOfCareRecord/Patient/ActorID]
1.08	Marital Status	cda:recordTarget/cda:patientRole/ cda:patient/ cda:maritalStatusCode	/ContinuityOfCareRecord/Body/SocialHistory/SocialHistoryElement/Type/[/Text=”Marital Status” or /Code] /ContinuityOfCareRecord/Body/SocialHistory/SocialHistoryElement/Description
1.09	Race	cda:recordTarget/cda:patientRole/ cda:patient/ cda:raceCode	/ContinuityOfCareRecord/Body/SocialHistory/SocialHistoryElement/Type/[/Text=”Race” or /Code] /ContinuityOfCareRecord/Body/SocialHistory/SocialHistoryElement/Description
1.10	Ethnicity	cda:recordTarget/cda:patientRole/ cda:patient/ cda:ethnicityCode	/ContinuityOfCareRecord/Body/SocialHistory/SocialHistoryElement/Type/[/Text=”Ethnicity” or /Code] /ContinuityOfCareRecord/Body/SocialHistory/SocialHistoryElement/Description

Table 6.5.1-1 Person Information Data Element Mappings

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6.4.2 LANGUAGE MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
2.01	Language	cda:recordTarget/cda:patientRole/ cda:patient/ cda:languageCommunication	/ContinuityOfCareRecord/Body/SocialHistory/SocialHistoryElement/Type/[/Text="Language Spoken" or /Code] /ContinuityOfCareRecord/Body/SocialHistory/SocialHistoryElement/Description

Table 6.5.2-1 Language Data Element Mappings

860

6.4.3 SUPPORT MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
3.01	Date	cda:participant/cda:time	/ContinuityOfCareRecord/DateTime
3.02	Contact Type/Relationship	cda:participant/ cda:associatedEntity/@classCode	/ContinuityOfCareRecord/Body/Support/SupportProvider/ActorRole
3.03	Contact Name	cda:participant/ cda:associatedEntity/ cda:associatedPerson/cda:name	/ContinuityOfCareRecord/Actors/Actor/Person/Name[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Support/SupportProvider/ActorID]
3.04	Contact Address	cda:participant/ cda:associatedEntity/cda:addr	/ContinuityOfCareRecord/Actors/Actor/Address[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Support/SupportProvider/ActorID]
3.05	Contact Phone/Email/URL	cda:participant/ cda:associatedEntity/cda:telecom	/ContinuityOfCareRecord/Actors/Actor/Telephone[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Support/SupportProvider/ActorID] /ContinuityOfCareRecord/Actors/Actor/EMail[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Support/SupportProvider/ActorID] /ContinuityOfCareRecord/Actors/Actor/URL[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Support/SupportProvider/ActorID]

Table 6.5.3-1 – Support Data Element Mappings

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870

6.4.4 HEALTHCARE PROVIDERS MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
4.01	Date	cda:participant/cda:time	/ContinuityOfCareRecord/DateTime
4.02	Provider Type	cda:performer	
4.03	Provider Role	cda:performer/cda:assignedEntity/ cda:code	/ContinuityOfCareRecord/Body/HealthCareProviders/Provider/ActorRole
4.04	Provider Name	cda:performer/cda:assignedEntity/ cda:assignedPerson/cda:name	/ContinuityOfCareRecord/Actors/Actor/Person/Name[ActorObjectID is equal to /ContinuityOfCareRecord/Body/HealthCareProviders/Provider /ActorID]
4.05	Provider Address	cda:performer/cda:assignedEntity/ cda:addr	/ContinuityOfCareRecord/Actors/Actor/Address[ActorObjectID is equal to /ContinuityOfCareRecord/Body/HealthCareProviders/Provider /ActorID]
4.06	Provider Phone/Email/URL	cda:performer/cda:assignedEntity/ cda:telecom	/ContinuityOfCareRecord/Actors/Actor/Telephone[ActorObjectID is equal to /ContinuityOfCareRecord/Body/HealthCareProviders/Provider /ActorID] /ContinuityOfCareRecord/Actors/Actor/EMail[ActorObjectID is equal to /ContinuityOfCareRecord/Body/HealthCareProviders/Provider /ActorID] /ContinuityOfCareRecord/Actors/Actor/URL[ActorObjectID is equal to /ContinuityOfCareRecord/Body/HealthCareProviders/Provider /ActorID]
4.07	Provider's Organization Name	cda:performer/cda:assignedEntity/ cda:id	/ContinuityOfCareRecord/Actors/Actor/IDs[ActorObjectID is equal to /ContinuityOfCareRecord/Body/HealthCareProviders/Provider /ActorID]
4.08	Provider's Patient ID	cda:performer/cda:assignedEntity/ pcc:patient/pcc:id	/ContinuityOfCareRecord/Actors/Actor/IDs[ActorObjectID is equal to /ContinuityOfCareRecord/Body/HealthCareProviders/Provider /ActorID]

Table 6.5.4-1 Healthcare Providers Data Element Mappings

875

6.4.5 INSURANCE PROVIDERS MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
5.01	Health Plan Begin Date	cda:participant[@typeCode='HLD']/ cda:time	/ContinuityOfCareRecord/DateTime

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
5.02	Health Insurance Type	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POLHOLD']/ cda:scopingOrganization/ cda:standardIndustryClassCode	/ContinuityOfCareRecord/Body/Payers/Payer/Type
5.03	Financial Responsibilty Party Type		/ContinuityOfCareRecord/Body/Payers/Payer[/Type/Description/Text = “Primary Health Insurance”]
5.04	Health Plan Insurance Information Source Name	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POLHOLD']/ cda:scopingOrganization/cda:name	/ContinuityOfCareRecord/Actors/Actor/Person/Name[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/PaymentProvider/ActorID]
5.05	Health Plan Name	pcc:sponsor/ cetc:sponsorPlan/ cetc:name	/ContinuityOfCareRecord/Body/Payers/Payer/Description/Text
5.06	Health Plan Insurance Information Source Address	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POLHOLD']/ cda:scopingOrganization/cda:addr	/ContinuityOfCareRecord/Actors/Actor/Address[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/ PaymentProvider /ActorID]
5.07	Health Plan Insurance Information Source Phone/Email/URL	cda:performer/cda:assignedEntity/ cda:telecom	/ContinuityOfCareRecord/Actors/Actor/Telephone[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/ PaymentProvider /ActorID] /ContinuityOfCareRecord/Actors/Actor/EMail[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/ PaymentProvider /ActorID] /ContinuityOfCareRecord/Actors/Actor/URL[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/ PaymentProvider /ActorID]
5.08	Health Plan Insurance Information Source ID	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POLHOLD']/ cda:scopingOrganization/cda:id	/ContinuityOfCareRecord/Actors/Actor/IDs[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/ PaymentProvider /ActorID]
5.09	Subscriber Name	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POLHOLD']/ cda:associatedPerson/cda:name	/ContinuityOfCareRecord/Actors/Actor/Person/Name[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/Subscriber/ActorID]
5.10	Subscriber Date of Birth	cda:participant[@typeCode='HLD']/cda:associatedEntity[@classCode='POLHOLD']/cda:associatedPerson/cetc:birthTime	/ContinuityOfCareRecord/Actors/Actor/Person/DateOfBirth[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/Subscriber/ActorID]
5.11	Subscriber Address	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POLHOLD']/ cda:addr	/ContinuityOfCareRecord/Actors/Actor/Address[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/Subscriber/ActorID]

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
5.12	Subscriber Phone/Email/URL	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POLH OLD']/ cda:telecom	/ContinuityOfCareRecord/Actors/Actor/Telephone[ActorObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/Sub scriber/ActorID] /ContinuityOfCareRecord/Actors/Actor/EMail[Acto rObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/Sub scriber/ActorID] /ContinuityOfCareRecord/Actors/Actor/URL[Actor ObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/Sub scriber/ActorID]
5.13	Group Number	cda:performer/cda:assignedEntity/pcc:spon sor/pcc:id	/ContinuityOfCareRecord/Body/Payers/Payer/IDs[/Type = “GroupID”]/ID
5.14	Subscriber ID	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POLH OLD']/ cda:associatedPerson/cda:id	/ContinuityOfCareRecord/Actors/Actor/EMail[Acto rObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/Sub scriber/ActorID]/IDs
5.15	Member ID	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POLH OLD']/ pcc:patient/pcc:id	/ContinuityOfCareRecord/Body/Payers/Payer/IDs[/Type = “GroupID”]/ID
5.16	Relationship to Subscriber	cda:participant[@typeCode='HLD']/ cda:associatedEntity[@classCode='POLH OLD']/ cda:code	/ContinuityOfCareRecord/Actors/Actor/EMail[Acto rObjectID is equal to /ContinuityOfCareRecord/Body/Payers/Payer/Sub scriber/ActorID]/Relation
5.17	Effective Date of Financial Responsibility	cda:participant[guar(@typeCode='HLD')]/cda:time	TBD
5.18	Financial Responsibility Party Address	cda:participant[@typeCode='GUAR']/cda:associatedEntity/ cda:addr	TBD
5.19	Financial Responsibility Party Phone/Email/URL	cda:participant[@typeCode='GUAR']/cda:associatedEntity/ cda:telecom	TBD
TBD 5.20	Patient Name	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity/ pcc:patient/cetc:patientAsKnown/ cetc:name	TBD
5.21	Patient Address	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity[@classCode='POLH OLD']/ pcc:patient/cetc:addr	TBD
5.22	Patient Phone/Email/URL	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity/ pcc:patient/cetc:telecom	TBD
5.23	Patient Date of Birth	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity/pcc:patient/ cetc:patientAsKnown/ cetc:birthTime	TBD

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
5.24	Financial Responsibility Party Name	cda:participant[@typeCode='HLD' or @typeCode='GUAR']/ cda:associatedEntity/ cda:associatedPerson/cda:name	TBD

Table 6.5.5-1 Insurance Providers Data Element Mappings

6.4.6 ALLERGIES AND DRUG SENSITIVIES MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
6.01	Allergy Date	cda:observation/cda:effectiveTime	/ContinuityOfCareRecord/Body/Alerts/Alert/DateTime
6.02	Allergy Type	cda:observation/cda:code	/ContinuityOfCareRecord/Body/Alerts/Alert/Type
6.03	Product Free-Text	cda:observation/ cda:participant[@typeCode='CSM']/ cda:participantRole[@classCode='MANU']/ cda:playingEntity[@classCode='MMAT']/cda:code/ cda:originalText	/ContinuityOfCareRecord/Body/Alerts/Alert/Products/Product/Description/Text
6.04	Reaction Free-Text	cda:observation/ cda:entryRelationship[@typeCode='MFST']/ cda:observation/cda:value/cda:originalText/ cda:reference/@value	/ContinuityOfCareRecord/Body/Alerts/Alert/Reaction/Description/Text
6.05	Severity Free-Text	cda:observation/ cda:entryRelationship[@typeCode='SUBJ']/ cda:observation/cda:code[@code='SEV']/ cda:value/cda:originalText/cda:reference/@value	/ContinuityOfCareRecord/Body/Alerts/Alert/Reaction/Severity/Description/Text
6.06	Product Coded	cda:observation/ cda:participant[@typeCode='CSM']/ cda:participantRole[@classCode='MANU']/ cda:playingEntity[@classCode='MMAT']/ cda:code	/ContinuityOfCareRecord/Body/Alerts/Alert/Products/Product/Description/Code
6.07	Reaction Coded	cda:observation/ cda:entryRelationship[@typeCode='MFST']/ cda:observation/cda:value	/ContinuityOfCareRecord/Body/Alerts/Alert/Reaction/Description/Code
6.08	Severity Coded	cda:observation/ cda:entryRelationship[@typeCode='SUBJ']/ cda:observation/cda:code[@code='SEV']/ cda:value	/ContinuityOfCareRecord/Body/Alerts/Alert/Reaction/Severity/Description/Code

Table 6.5.6-1 Allergies and Drug Sensitivities Data Element Mappings

6.4.7 CONDITIONS MODULE

890

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
7.01	Problem Date	cda:observation/cda:effectiveTime	/ContinuityOfCareRecord/Body/Problems/Problem /DateTime
7.02	Problem Type	cda:observation/cda:code	/ContinuityOfCareRecord/Body/Problems/Problem /Type
7.03	Problem Name	cda:observation/cda:value/cda:original Text/ cda:reference/@value	/ContinuityOfCareRecord/Body/Problems/Problem /Description/Text
7.04	Problem Code	cda:observation/cda:value	/ContinuityOfCareRecord/Body/Problems/Problem /Description/Code

Table 6.5.7-1 Conditions Data Element Mappings

6.4.8 MEDICATIONS – PRESCRIPTION AND NON-PRESCRIPTION MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
8.01	Order Date/Time	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:time	/ContinuityOfCareRecord/Body/Medications/Medication/DateTime[/Type = “Order Date”]

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
8.02	Type of Medication	cda:substanceAdministration/ cda:consumable/ cda:manufacturedProduct/ cda:manufacturedLabeledDrug/ cda:code/cda:translation	/ContinuityOfCareRecord/Body/Medications/Medication/Type
8.03	Free Text Product Name	cda:substanceAdministration/ cda:consumable/cda:manufacturedProduct/ cda:manufacturedLabeledDrug/cda:name	/ContinuityOfCareRecord/Body/Medications/Medication/Product/ProductName/Text
8.04	Coded Product Name	cda:substanceAdministration/ cda:consumable/cda:manufacturedProduct/ cda:manufacturedLabeledDrug/cda:code	/ContinuityOfCareRecord/Body/Medications/Medication/Product/ProductName/Code
8.05	Free Text Brand Name	cda:substanceAdministration/ cda:consumable/cda:manufacturedProduct/ cda:manufacturedLabeledDrug/cda:name	/ContinuityOfCareRecord/Body/Medications/Medication/Product/BrandName/Text
8.06	Coded Brand Name	cda:substanceAdministration/ cda:consumable/cda:manufacturedProduct/ cda:manufacturedLabeledDrug/cda:code	/ContinuityOfCareRecord/Body/Medications/Medication/Product/BrandName/Code
8.07	Status of Medication	cda:substanceAdministration/cda:entryRelationship/ cda:observation/cda:code[@code='CLINSTATUS' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	/ContinuityOfCareRecord/Body/Medications/Medication/Status
8.08	Drug Manufacturer	cda:substanceAdministration/ cda:consumable/cda:manufacturedProduct/ cda:manufacturerOrganization/	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Manufacturer/ActorID
8.09	Product Form	cda:substanceAdministration/ cda:administrationUnitCode	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Form
8.10	Product Concentration		/ContinuityOfCareRecord/Body/Medications/Medication/Product/Concentration
8.11	Quantity Ordered	cda:supply/cda:quantity	/ContinuityOfCareRecord/Body/Medications/Medication/Quantity
8.12	Free Text Sig	cda:substanceAdministration/ cda:text	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/Description/Text
8.13	Dose Indicator	cda:substanceAdministration/ cda:precondition/cda:criteria	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/DoseIndicator
8.14	Delivery Method	cda:substanceAdministration/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/DeliveryMethod
8.15	Dose	cda:substanceAdministration/ cda:doseQuantity	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/Dose

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
8.16	Vehicle	cda:substanceAdministration/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/Vehicle
8.17	Route	cda:substanceAdministration/cda:routeCode	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/Route
8.18	Site	cda:substanceAdministration/cda:approachSiteCode	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/Site
8.19	Administration Timing	cda:substanceAdministration/cda:effectiveTime[2]	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/AdministrationTiming
8.20	Frequency	cda:substanceAdministration/cda:effectiveTime[2]	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/Frequency
8.21	Interval	cda:substanceAdministration/cda:effectiveTime[2]	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/Interval
8.22	Duration	cda:substanceAdministration/cda:effectiveTime[2]	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/Duration
8.23	Dose Restriction	cda:substanceAdministration/cda:maxDoseQuantity	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/DoseRestriction
8.24	Indication	cda:substanceAdministration/cda:entryRelationship[@typeCode='RSON']/cda:observation	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/Indication
8.25	Indicate Medication Stopped	cda:substanceAdministration/cda:effectiveTime[1]/cda:high	/ContinuityOfCareRecord/Body/Medications/Medication/Product/Directions/Direction/StopIndicator
8.26	Patient Instructions	cda:substanceAdministration/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	/ContinuityOfCareRecord/Body/Medications/Medication/PatientInstructions
8.27	Fullfillment Instructions	cda:supply/cda:entryRelationship/cda:observation/cda:code[@code='INSTRUCT' and @codeSystem='1.3.6.1.4.1.19376.1.5.3.2']	/ContinuityOfCareRecord/Body/Medications/Medication /FulfillmentInstructions
8.28	Refills	cda:supply/cda:repeatNumber	/ContinuityOfCareRecord/Body/Medications/Medication/Refills
8.29	Reaction		/ContinuityOfCareRecord/Body/Medications/Medication/Reaction
8.30	Fulfillment History	cda:supply/cda:repeatNumber	Free Text: /ContinuityOfCareRecord/Body/Medications/Medication/FulfillmentHistory/Fulfillment/Description/Text
8.31	Provider	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:assignedAuthor/cda:assignedPerson	/ContinuityOfCareRecord/Body/Medications/Medication/FulfillmentHistory/Fulfillment/Provider
8.32	Location	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:assignedAuthor/cda:representedOrganization	/ContinuityOfCareRecord/Body/Medications/Medication/FulfillmentHistory/Fulfillment/Location

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
8.33	Dispense Date	cda:substanceAdministration[@moodCode='RQO']/ ancestor-or-self::cda:author/cda:assignedAuthor/ cda:representedOrganization	/ContinuityOfCareRecord/Body/Medications/Medication/FulfillmentHistory/Fulfillment/DateTime[/Type = “Dispense Date”]
8.34	Quantity Dispensed	cda:supply/cda:quantity	/ContinuityOfCareRecord/Body/Medications/Medication/FulfillmentHistory/Fulfillment/Quantity
8.35	Prescription Number		
8.36	Source of the Medication Information	cda:substanceAdministration/ ancestor-or-self::cda:informant	/ContinuityOfCareRecord/Body/Medications/Medication/Source
8.37	Ordering Provider	TBD	/ContinuityOfCareRecord/Body/Medications/Medication/Source[/Actor/ActorRole = “Prescriber”]

Table 6.5.8-1 Prescription and Non-Prescription Data Element Mappings

6.4.9 PREGNANCY MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
9.01	Pregnancy	cda:observation[cda:code[@code='11449-6' and @codeSystem='2.16.840.1.113883.1']]/ cda:value	/ContinuityOfCareRecord/Body/Problems/Problem[/Description/Text = “Pregnant”]

Table 6.5.9-1 Pregnancy Data Element Mappings

6.4.10 INFORMATION SOURCE MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
10.01	Author Name	cda:author/cda:assignedAuthor/cda:name	TBD
10.02	Author Time	cdc:author/cda:time	TBD
10.03	Reference	cda:reference/cda:externalDocument	TBD
10.04	Reference Document ID	cda:reference/cda:externalDocument/ cda:id	TBD
10.05	Reference Document URL	cda:reference/cda:externalDocument/ cda:text/cda:reference/@value	TBD

Table 6.5.10-1 – Information Source Data Element Mappings

6.4.11 COMMENTS MODULE

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
11.01	Author Name	cda:author/cda:name	TBD
11.02	Date	cda:author/cda:time	TBD
11.03	Free Text Comment	cda:text/cda:reference/@value[3]	TBD

915 Table 6.5.11-1 Comments Data Element Mappings

6.4.12 ADVANCE DIRECTIVES

920

Data Elem. ID	Data Element	CCD/XPHR Name	ASTM E2369-05 CCR Name
12.01	Effective Date	cda:act/ cda:effectiveTime	TBD
12.02	Advance Directive Type	cda:act/cda:code	TBD
12.03	Custodian of the Document	cda:act/cda:participant[@typeCode='CST']	TBD

Table 6.5.12-1 Advance Directives Data Element Mappings

925

[3] A pointer to the narrative that contains the free text.