HITSP Data Dictionary Component

HITSP/C154

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Note to Reviewers: *This document serves as a catalog of data element-related information; as such it is subject to frequent and regular updates. To facilitate the review of this document, the* <mark>changes specific to each published version will be highlighted within the document</mark>*. A reviewer may review the entire document, but note that special emphasis is placed on the review of proposed changes and new items. All submitted comments must reference the specific version of the document being reviewed for proper resolution.*

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1.0 INTRODUCTION

1.1 OVERVIEW

This specification is a library of the HITSP defined data elements that are used for mapping to data elements from the HITSP selected standards. It defines data elements that have been constrained or used in other HITSP documents (such as Components, Transactions, Transaction Packages) and facilitates the consistent use of these data elements across the various HITSP selected standards. It does not attempt to specify all the data elements for the standards selected by HITSP (i.e. only those constrained). The Data Elements are organized into modules to simplify navigation, such as Medications, Advance Directives, Immunizations, etc.

This specification does not enable the use of the data elements; this is accomplished by a HITSP construct that is based upon a specific standard (such as HL7, X12N, NCPDP, etc.). In order to facilitate harmonization of value sets across the various selected standards, this specification may define value set constraints. When this does not occur, it is because the data element does not require a value set or a harmonized value set was not determined. These value sets in turn reference standard terminologies in HITSP/C80 Clinical Document Message Terminology. HITSP/C154 does not define any other constraints (such as optionality) as those constraints are identified in the HITSP construct that enables the data element.

There are many ways that various HITSP documents may constrain a data element, some examples include:

- Specifying the Optionality of a data element, such as required, required if known or conditional
- Selecting value sets for the data element (which may be the same as HITSP/C154 or additional constraints)
- Refining the information that may be provided in that data element when it is used in an exchange

HITSP/TN903 Data Architecture provides a more detailed explanation about the use of data elements (and other data architecture concepts) within HITSP.

1.2 COPYRIGHT PERMISSIONS

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1.3 REFERENCE DOCUMENTS

A list of key reference documents and background material is provided in the table below. HITSP-maintained reference documents can be retrieved from the HITSP Web Site.

Table 1-1 Reference Documents

Reference Document	Document Description
HITSP Acronyms List	Lists and defines the acronyms used in this document
HITSP Glossary	Provides definitions for relevant terms used by HITSP documents
TN901 - Clinical Documents	TN901 is a reference document that provides the overall context for use of the HITSP Care Management and Health Records constructs
TN903 – Data Architecture	TN903 is a reference document that provides the overall context for use of the HITSP Data Architecture constructs
TN904 – Harmonization Framework and Exchange Architecture	TN904 is a reference document that provides the overall context for use of the HITSP Harmonization Framework and Exchange Architecture

1.4 CONFORMANCE

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

1.4.1 CONFORMANCE CRITERIA

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

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

1.4.2 CONFORMANCE SCOPING, SUBSETTING AND OPTIONS

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

1.5 DOCUMENT CONVENTIONS

1.5.1 KEY WORDS

The key words **SHALL**, **SHALL NOT**, **SHOULD**, **SHOULD NOT** and **MAY** are to be interpreted as described in RFC 2119 and will appear when used in that fashion in this **TYPEFACE**.

The key words **REQUIRED** and **OPTIONAL** are also to be interpreted as described in RFC 2119 when they are used to indicate the optionality of components used in an exchange.

1.5.2 CONSTRAINTS

Constraints in this document will appear as shown below.

C154-[DE-7.04-1]   The problem type **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.1.4.1.2 Problem Type. The first portion identifies the type of artifact being constrained. The second portion is the identifier for that artifact, and the final portion is the sequence

number of the constraint on that artifact within this document. Constraints specific to CDA usage will contain the term CDA before the final number.

2.0 DATA DICTIONARY DEFINITION

2.1 CONTEXT OVERVIEW

This section provides an introduction to the concepts used in describing the data elements used in HITSP specifications. The HITSP Data Elements in this document are organized into modules described in Table 2-1 below. The module identifier number is given in the first column, followed by the name and definition of what appears in that module. These modules are described in more detail below in Section 2.1.2 HITSP Data Elements.

Table 2-1 Module Categories

Number	Module Name	Definition
1	Personal Information	This includes name, address, contact information, personal identification information, ethnic and racial affiliation and marital status of a person
2	Language	This includes the language spoken by the subject
3	Support	This includes the patient's sources of support, such as immediate family, relatives and/or guardians. This includes next of kin, caregivers, support organizations, and key contacts relative to healthcare decisions. Support providers may include providers of healthcare related services, such as a personally controlled health record, or registry of emergency contacts
4	Healthcare Providers	This includes a list of the healthcare providers and organizations that provide or have provided care to the patient
5	Insurance Providers and Payers	This includes data about the organizations or individuals who may pay for a patient's healthcare, and the relationships, demographics and identifiers of those individuals with respect to the payer. Such organizations or individuals may be health insurance plans, other payers, guarantors, parties with financial responsibility, some combination of payers or the patient directly
6	Allergies and Drug Sensitivities	This includes the allergy or intolerance conditions, severity and associated adverse reactions suffered by the patient
7	Conditions	This includes relevant clinical problems and conditions for which the patient is receiving care, including information about onset, severity, and providers treating the condition. Conditions are broader than, but include diagnoses
8	Medications	This includes the patient's prescription or non-prescription medications and medication history, and may include prescriptions, fulfillments and medication administration activities
9	Pregnancy	This includes information about the patient's current and past pregnancy status
10	Information Source	This includes information about the author or creator of the information contained within the exchange
12	Advanced Directive	This includes data defining the patient's advance directives and supporting documentation. It can include information about the existence of living wills, healthcare proxies, and CPR and resuscitation status
13	Immunizations	This includes data describing the patient's immunization history
14	Vital Signs	This includes data about the patient's vital signs
15	Test Results	This includes data about current and historical test results from laboratory or other diagnostic testing performed on the patient
16	Encounter	This includes data describing the interactions between the patient and clinicians. Interaction includes both in-person and non-in-person encounters such as telephone and email
17	Procedures	This includes data describing procedures performed on a patient
18	Family History	This includes data defining the patient's genetic relatives in terms of possible or relevant health risk factors that have a potential impact on the patient's health
19	Social History	This includes data defining the patient's occupational, personal (e.g. lifestyle), social, and environmental history that have a potential impact on the patient's health
20	Medical Equipment	This includes implanted and external medical devices and equipment that a patient's health status depends on, as well as any pertinent equipment or device history

Number	Module Name	Definition
21	Functional Status	This includes data defining the patient's functional status with respect to, Ambulatory ability, Mental status or competency, Activities of Daily Living, including bathing, dressing, feeding, grooming, Home/living situation having an effect on the health status of the patient, Ability to care for self
22	Plan of Care	This includes data defining prospective or intended orders, interventions, encounters, services, and procedures for the patient
23	Clinical Research	This includes data elements and common identifier variables that pertain to research-specific workflow
24	Order	This includes data describing orders for a patient
25	Specimen	This includes data describing the specimen information associated with an order and the results

HITSP committees define HITSP Data Elements in response to the business requirements identified for an information exchange. The domain committees use existing data elements defined in this specification where feasible, and identify new data elements when existing data elements do not meet the established business requirements.

Other HITSP specifications may also provide additional constraints to those in this document, therefore, implementers **SHALL** comply with data element constraints for HITSP data elements defined Section 2.1.2 and **SHALL** comply with the data element constraints in HITSP Components, Transactions and Transaction Packages.

2.1.1   DATA DICTIONARY CONSTRAINTS

This section describes the data elements of each of the modules and the constraints that are placed upon the use of the data elements described in these modules.

Table 2-2 Data Element Definition

Identifier	Name	Definition	Constraints
A numeric identification of the data element used to reference it	The name of the data element being defined	A concise definition of the data element	Additional HITSP constraints for this data element

2.1.1.1   DATA ELEMENT IDENTIFIER

Each data element has an identifier that uniquely identifies it. The first part of the identifier is assigned based upon the module where it is found. The second part of the identifier uniquely identifies the element within the module. As new data elements are created, they are added to the end of the data module. The data element identifiers are persistent and will not be changed or reused between versions of HITSP specifications.

2.1.1.2   DATA ELEMENT NAME

Each data element has a name that briefly describes the content and purpose of the data element. Data element names may be changed between versions of HITSP specifications to better describe the content and purpose.

2.1.1.3   DATA ELEMENT DEFINITION

Each HITSP data element has a definition that is intended to precisely describe the purpose and structure of the data element independent from the standards that it may be mapped to. This independence allows HITSP data elements to be mapped to data elements using a variety of standards. The concise definition and mapping to the standards data element also supports harmonization of data across exchanges using different standards. The definition should describe the data element with sufficient enough detail to clearly indicate the purpose and content of the data element.

2.1.1.4   DATA ELEMENT CONSTRAINTS

In some cases, the data element will have additional restrictions limiting the values that can be communicated within it. HITSP may apply restrictions to a data element when it is communicated. These restrictions could be with regard to its precision, the units, and the range of legal values that may be transmitted or other restrictions as necessary. These will be described in or referred to by this column.

This column defines universal constraints that apply to data elements regardless of the Base Standard (i.e. HL7 CDA, HL7 V2 messages, NCPDP, etc.) allowing for harmonized constraints across the various Base Standards. Additional data element constraints may also be defined in the CDA-specific sections of this document (2.2.x), or in HITSP Components, Transactions, Transaction Packages or Interoperability Specifications.

2.1.2   HITSP DATA ELEMENTS

2.1.2.1   PERSONAL INFORMATION

The personal information module contains the name, address, contact information, personal identification information, ethnic and racial affiliation and marital status of the person. See the HL7 Continuity of Care Document Section 2.5 for constraints applicable to this module.

Table 2-3 Person Information Data Mapping Table – Definitions

Identifier	Name	Definition	Constraints
1.01	Timestamp	The date and time that this exchange has been created	

Table 2-4 Person Information Data Mapping Table – Definitions: Patient Information Event Entry

Identifier	Name	Definition	Constraints
1.02	Person ID	An identifier that uniquely identifies the individual to which the exchange refers and connects that document to the individual's personal health record. Potential security risks associated with use of SSN or driver's license for this element suggest that these should not be used routinely	
1.03	Person Address	The current address of the individual to which the exchange refers. Multiple addresses are allowed and the work address may be a method of disclosing the employer	C154-[DE-1.03-1] The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State C154-[DE-1.03-2] The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code C154-[DE-1.03-3] The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country
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. HITSP specifies just this one data element to describe phone numbers, pagers, e-mail addresses and URLs, but these may appear in different data elements in the selected standards. The patient may designate one or more of these contact numbers as the preferred method of contact and temporary items can be entered for use on specific effective dates	

Table 2-5 Person Information Data Mapping Table – Definitions: Personal Information

Identifier	Name	Definition	Constraints
1.05	Person Name	The individual to whom the exchange refers. Multiple names are allowed to retain birth name, maiden name, legal names and aliases as required	
1.06	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 exchange 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 filed, as well as the same information given to other healthcare providers, institutions or health data exchange networks	C154-[DE-1.06-1] Gender **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.1. Administrative Gender
1.07	Person Date of Birth	The date and time of birth of the individual to which this Exchange 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	
1.08	Marital Status	A value representing the domestic partnership status of a person. Marital status is 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 be 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 Exchange is produced. Former values might be part of the personal and social history	C154-[DE-1.08-1] Marital Status **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.3.2 Marital Status CDA and HLV3
1.09	Religious Affiliation	Religious affiliation is the religious preference of the person	C154-[DE-1.09--1] Religious affiliation **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.8 Religious Affiliation
1.10	Race	Race is usually a single valued term that may be constant over that patient's lifetime. The coding of race is 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. In this event, some healthcare organizations that receive the Summary Document may choose to enter an observed race as their current practice for manual registration. Such organization observed race data should be differentiated from patient sourced data in the patient's registration summary	C154-[DE-1.10-1] Race **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.7 Race
1.11	Ethnicity	Ethnicity is a term that extends the concept of race. The coding of ethnicity is aligned with public health and other federal reporting standards of the CDC and the Census Bureau	C154-[DE-1.11-1] Ethnicity **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.2 Ethnicity
1.12	Mother's Maiden Name	The family name under which the Mother was born	
1.13	Multiple Birth Indicator	Indicates whether a patient was part of a multiple birth	

Identifier	Name	Definition	Constraints
1.14	Birth Order	The value (number) indicating the patient's birth order when the patient was part of a multiple birth	
1.15	Age	The Person's age. This is normally a value derived, but in some cases this may be the only information provided (no birth date)	C154-[DE-1.15-1]] The Age **SHALL** use UCUM Age Units
1.16	Birth Place	The location of the patient's birth	C154-[DE-1.16-1] If born in the United States, the state part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State C154-[DE-1.16-2] If born in the United States the postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code C154-[DE-1.16-3] The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country
1.17	Identity Unknown Indicator	Indicates whether or not the patient's/person's identity is known	
1.18	Patient Account Number	The patient account number assigned by accounting to which all charges, payments, etc., are recorded	

2.1.2.2   LANGUAGE SPOKEN

This module indicates the language spoken by the subject.

Table 2-6 Language Spoken Data Mapping Table – Definitions

Identifier	Name	Definition	Constraints
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	C154-[DE-2.01-1] Language **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.9 Language C154-[DE-2.01-2] Sign language **SHALL** be treated as a separate language

2.1.2.3   SUPPORT

This module contains the patient's sources of support, such as immediate family, relatives and guardians. Support information also includes next of kin, caregivers and support organizations. Support providers may include providers of healthcare related services, such as a personally controlled health record, or registry of emergency contacts.

Table 2-7 Support Data Mapping Table – Definitions: Support

Identifier	Name	Definition	Constraints
3.01	Date	The period over which the support is provided	

Table 2-8 Support Data Mapping Table – Definitions: Contact

Identifier	Name	Definition	Constraints
3.02	Contact Type	This represents the type of support provided, such as immediate emergency contacts, next of kin, family relations, guardians, agents, etc	
3.03	Contact Relationship	Identifies the relationship of the contact person to the individual for which this exchange refers	C154-[DE-3.03-1] The contact relationship **SHALL** have be coded as specified in HITSP/C80 Section 2.2.1.2.4 Personal Relationships

Identifier	Name	Definition	Constraints
3.04	Contact Address	The address of the contact individual or organization providing support to the individual for which this exchange is produced	C154-[DE-3.04-1] The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State C154-[DE-3.04-2] The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code C154-[DE-3.04-3] The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country
3.05	Contact Phone/Email/URL	A telephone number (voice or fax), e-mail address, or other locator for the contact individual or organization providing support to the individual for which this exchange is produced. One data element is used to describe phone numbers, pagers, e-mail addresses and URLs	
3.06	Contact Name	The name of the individual or organization providing support to the individual for which this exchange is produced	

2.1.2.4   HEALTHCARE PROVIDER

This module contains the healthcare providers involved in the current or pertinent historical care of the patient.

Table 2-9 Healthcare Providers Data Mapping Table – Definitions: Provider

Identifier	Name	Definition	Constraints
4.01	Date Range	The period over which this provider has provided healthcare services to the patient	
4.02	Provider Role Coded	Provider role uses a coded value to classify providers according to the role they play in the healthcare of the patient and comes from a very limited set of values. The purpose of this data element is to express the information often required during patient registration, identifying the patient's primary care provider, the referring physician or other consultant involved in the care of the patient	C154-[DE-4.02-1] Provider role **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.8.1 Provider Role
4.03	Provider Role Free Text	This unstructured text classifies providers according to the role they play in the healthcare of the patient	

Table 2-10 Healthcare Providers Data Mapping Table – Definitions: Provider Entity

Identifier	Name	Definition	Constraints
4.04	Provider Type	Provider type classifies providers according to the type of license or accreditation they hold (e.g. physician, dentist, pharmacist, etc.) or the service they provide	C154-[DE-4.04-1] Provider type **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.8.2 Provider Type

Identifier	Name	Definition	Constraints
4.05	Provider Address	The mailing address to which written correspondence to this provider should be directed	C154-[DE-4.05-1] The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State C154-[DE-4.05-2] The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code C154-[DE-4.05-3] The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country
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, e-mail 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 Name	The name of the provider	
4.08	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	
4.09	Provider's Patient ID	The identifier used by this provider to identify the patient's medical record	
4.10	National Provider ID	National Provider Identifier or NPI is a unique identification number issued to healthcare providers in the United States	

2.1.2.5 INSURANCE PROVIDER

This insurance provider module contains data about the entities or other individuals who may pay for a patient's healthcare. Such entities or individuals may be health insurance plans, other payers, and 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.

Table 2-11 Insurance Provider Data Mapping Table – Definitions: Payment Provider Event Entry

Identifier	Name	Definition	Constraints
5.01	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	
5.02	Health Insurance Type	The type of health plan covering the individual, e.g., an HMO, PPO, POS, Medicare Part A/B, etc	C154-[DE-5.02-1] The Health Insurance Type **SHALL** be coded as specified in HITSP/C80 Section 2.2.2.1 Health Insurance Type

Table 2-12 Insurance Provider Data Mapping Table – Definitions: Payer

Identifier	Name	Definition	Constraints
5.03	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)	
5.04	Health Plan Insurance Information Source Address	The official mailing address to which written correspondence is to be directed	C154-[DE-5.04-1] The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State C154-[DE-5.042] The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code C154-[DE-5.04-3] The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country
5.05	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, e-mail addresses, and URLs. One or more of these contact numbers can be designated as the preferred method(s) of contact; temporary items can be entered for use on specific effective dates	
5.06	Health Plan Insurance Information Source Name	The name of the entity that is the source of information about 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 X12N 271 Transaction, an information source could be the payer, a Third Party Administrator (TPA), a health plan sponsor, or a gateway provider	

Table 2-13 Insurance Provider Data Mapping Table – Definitions: Patient

Identifier	Name	Definition	Constraints
5.08	Member ID	The identifier assigned by the health plan to the patient who is covered 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. A related spouse, child, or dependent may not have a unique identification number of their own	
5.09	Patient Relationship to Subscriber	Specifies only if patient is the subscriber or dependent within the context of the specified health plan	C154-[DE-5.09-1] The Patient Relationship to Subscriber **SHALL** be coded as specified in HITSP/C80 Section 2.2.2.2 Subscriber Relationship

Identifier	Name	Definition	Constraints
5.10	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	C154-[DE-5.10-1] The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State C154-[DE-5.10-2] The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code C154-[DE-5.10-3] The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country
5.11	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, e-mail addresses and URLs. One or more of these contact numbers can be designated as the preferred method(s) of contact; temporary items can be entered for use on specific effective dates	
5.12	Patient Name	The name of the actual patient who is a member or enrollee of a health plan as entered into the eligibility system of the health plan. The patient may be the true subscriber or any related spouse, child, or dependent	
5.13	Patient Date of Birth	The date of birth of the patient as entered into the eligibility system of the health plan	
5.14	Financial Responsibility Party Type	The type of party that has responsibility for all or a portion of the patient's healthcare; includes health insurance, the patient directly, a guardian or other guarantor or other third party that is not a health insurance plan	

Table 2-14 Insurance Provider Data Mapping Table – Definitions: Patient Information

Identifier	Name	Definition	Constraints
5.07	Health Plan Coverage Dates	The beginning and end dates of the health plan coverage of the individual. These dates may not apply equally to all benefits included in the health plan coverage. Some benefits may have waiting periods for coverage to be effective which results in a different benefit begin date. The purpose of providing this information in the registration/medication summary is to better inform patients about their health coverage. Providers should use the applicable standard transactions required under regulation to determine patient eligibility for benefits	

Table 2-15 Insurance Provider Data Mapping Table – Definitions: Patient

Identifier	Name	Definition	Constraints
5.08	Member ID	The identifier assigned by the health plan to the patient who is covered 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. A related spouse, child, or dependent may not have a unique identification number of their own	

Identifier	Name	Definition	Constraints
5.09	Patient Relationship to Subscriber	Specifies only if patient is the subscriber or dependent within the context of the specified health plan	C154-[DE-5.09-1] The Patient Relationship to Subscriber SHALL be coded as specified in HITSP/C80 Section 2.2.2.2 Subscriber Relationship
5.10	Patient Address	The mailing address of the patient who is a member or enrollee of the 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	C154-[DE-5.10-1] The state part of an address in the United States SHALL be recorded using HITSP/C80 Section 2.2.1.1.1 State C154-[DE-5.10-2] The postal code part of an address in the United States SHALL be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code C154-[DE-5.10-3] The country part of an address SHALL be recorded using HITSP/C80 Section 2.2.1.1.3 Country
5.11	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, e-mail addresses and URLs. One or more of these contact numbers can be designated as the preferred method(s) of contact; temporary items can be entered for use on specific effective dates	
5.12	Patient Name	The name of the actual patient who is a member or enrollee of a health plan as entered into the eligibility system of the health plan. The patient may be the true subscriber or any related spouse, child, or dependent	
5.13	Patient Date of Birth	The date of birth of the patient as entered into the eligibility system of the health plan	
5.14	Financial Responsibility Party Type	The type of party that has responsibility for all or a portion of the patient's healthcare; includes health insurance, the patient directly, a guardian or other guarantor or other third party that is not a health insurance plan	

Table 2-16 Insurance Provider Data Mapping Table – Definitions: Subscriber Information

Identifier	Name	Definition	Constraints
5.15	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	
5.16	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	C154-[DE-5.16-1] The state part of an address in the United States SHALL be recorded using HITSP/C80 Section 2.2.1.1.1 State C154-[DE-5.16-2] The postal code part of an address in the United States SHALL be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code C154-[DE-5.16-3] The country part of an address SHALL be recorded using HITSP/C80 Section 2.2.1.1.3 Country

Identifier	Name	Definition	Constraints
5.17	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, e-mail addresses and URLs. One or more of these contact numbers can be designated as the preferred method(s) of contact; temporary items can be entered for use on specific effective dates	
5.18	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	
5.19	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	

Table 2-17 Insurance Provider Data Mapping Table – Definitions: Guarantor Information

Identifier	Name	Definition	Constraints
5.20	Effective Date of Financial Responsibility	The time span over which the Financial Responsibility Party is responsible for the payment of the patient's healthcare	
5.21	Financial Responsibility Party Address	The official mailing address of the Financial Responsibility Party to which written correspondence is to be directed	C154-[DE-5.21-1] The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State C154-[DE-5.21-2] The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code C154-[DE-5.21-3] The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country
5.22	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, e-mail addresses, and URLs. One or more of these contact numbers can be designated as the preferred method(s) of contact; temporary items can be entered for use on specific effective dates	
5.23	Financial Responsibility Party Name	The name of the Financially Responsible Party	
5.26	Advanced Beneficiary Notice	The status of the patient's or the patient's representative's consent for responsibility to pay for potentially uninsured services. This element indicates (a) whether the associated diagnosis codes for the service are subject to medical necessity procedures, (b) whether, for this type of service, the patient has been informed that they may be responsible for payment for the service, and (c) whether the patient agrees to be billed for this service	

Table 2-18 Insurance Provider Data Mapping Table – Definitions: Health Plan

Identifier	Name	Definition	Constraints
5.24	Health Plan Name	The name of the specific health insurance product as specified by the insurance company offering the healthcare insurance. The HIPAA legislation requires the Secretary of HHS to establish unique health plan identifiers. To date, the Secretary of HHS has not promulgated plans for regulations specifying the enumeration and identification of health plans	
5.25	Insurance Company Name	The name of the insurance company. There may be multiple names for the same insurance company. The first name listed is assumed to be the legal name	

2.1.2.6   ALLERGY/DRUG SENSITIVITY

This module contains the allergy or intolerance conditions and the associated adverse reactions suffered by the patient.

Table 2-19 Allergy/Drug Sensitivity Data Mapping Table – Definitions: Adverse Event Entry

Identifier	Name	Definition	Constraints
6.01	Adverse Event Date	This is a date that expresses when this particular allergy or intolerance was known to be active for the patient	
6.02	Adverse Event Type	Describes the type of product and intolerance suffered by the patient. The type of product shall be classified with respect to whether the adverse event occurs in relationship with a medication, food, or environmental or other product. The adverse event should also be classified more specifically as an allergy, non-allergy intolerance, or just adverse reaction if that level of detail is not known	C154-[DE-6.02-1] The vocabulary used for adverse event types **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.4.2 Allergy/Adverse Event Type

Table 2-20 Allergy/Drug Sensitivity Data Mapping Table – Definitions: Product

Identifier	Name	Definition	Constraints
6.03	Product Free-Text	This is the name or other description of the product or agent that causes the intolerance	
6.04	Product Coded	This value is a code describing the product	C154-[DE-6.04-1] Food and non-medicinal allergies/Sensitivities **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.11 Ingredient Name C154-[DE-6.04-2] Allergies/Drug Sensitivity to a class of medication **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.9 Medication Drug Class Note: HITSP/C80 Section 2.2.3.3.9 allows for more than one NDF-RT classification concept to accurately represent drug class for many medications. C154-[DE-6.04-3] Allergies/Drug Sensitivity to a specific medication **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.7 Medication Brand Name or HITSP/C80 Section 2.2.3.3.8 Medication Clinical Drug Names

Table 2-21 Allergy/Drug Sensitivity Data Mapping Table – Definitions: Reaction

Identifier	Name	Definition	Constraints
6.05	Reaction Free-Text	This is the reaction that may be caused by the product or agent	
6.06	Reaction Coded	This value is a code describing the reaction	C154-[DE-6.06-1] The reaction **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.4.1 Allergy/Adverse Event (Reaction)

Table 2-22 Allergy/Drug Sensitivity Data Mapping Table – Definitions: Severity

Identifier	Name	Definition	Constraints
6.07	Severity Free-Text	This is a description of the level of severity of the allergy or intolerance	
6.08	Severity Coded	This value is a code describing the level severity of the allergy or intolerance	C154-[DE-6.08-1] The terminology used for severity of the adverse event **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.4.3 Allergy/Adverse Event Severity

2.1.2.7   CONDITION

This module contains relevant clinical problems. See the HL7 Continuity of Care Document Section 3.5 for constraints applicable to this module.

Table 2-23 Conditions Data Mapping Table – Problem Event Entry

Identifier	Name	Definition	Constraints
7.01	Problem Date	This is the range of time of which the problem was active for the patient or subject	
7.02	Problem Type	This is a fixed value indicating the level of medical judgment used to determine the existence of a problem	C154-[DE-7.02-1] The problem type **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.2 Problem Type
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	C154-[DE-7.04-1] The problem **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.1 Problem
7.05	Treating Provider	The provider or providers treating the patient or subject for this condition	
7.06	Age (at Onset)	The age of the patient or subject at onset of the condition	
7.07	Cause of Death	Indicates that this problem was one of the causes of death for the patient or subject of the condition	
7.08	Age (at Death)	The age of the patient or subject at death	
7.09	Time of Death	The date/time the patient or subject's death occurred	
7.10	Diagnosis Priority	A number indicating the significance or the priority of the diagnosis code. It is used to distinguish between the primary and other diagnoses	C154-[DE-7.10-1] The problem **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.4 Diagnosis Priority
7.11	Treating Provider ID	The identifier assigned the treating provider (National Provider ID)	
7.12	Problem Status	The status of the problem (active, inactive, resolved)	C154-[DE-7.12-1] The problem **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.8 Problem Status

2.1.2.8   MEDICATION

This module contains a patient's prescription or non-prescription medications and pertinent medication history. See the HL7 Continuity of Care Document Section 3.9 for constraints applicable to this module.

Table 2-24 Prescription & Non-Prescription Data Mapping - Definitions: Administration Info Event Entry

Identifier	Name	Definition	Constraints
8.01	Free Text Sig	The instructions, typically from the ordering provider, to the patient on the proper means and timing for the use of the product. This information is free-text but can also be represented as a series of Sig Components	
8.02	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	
8.03	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	
8.04	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)	
8.05	Interval	A Sig Component: defines how the product is to be administered as an 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)	
8.06	Duration	A Sig Component: for non-instantaneous administrations, indicates the length of time the administration should be continued. For example, (infuse) over 30 minutes	
8.07	Route	A Sig Component: indicates how the medication is received by the patient (e.g., by mouth, intravenously, topically, etc.)	C154-[DE-8.07-1] **SHOULD** be coded using value sets consistent with those specified in HITSP/C80 Section 2.2.3.3.4.1 Medication Route FDA[1]
8.08	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)	C154-[DE-8.08-1] Units **MAY** be present when needed. If present it **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.6.6 Units of Measurement C154-[DE-8.08-2] When the coded product or brand name describes the strength or concentration of the medication, and the dosing is in administration units (e.g., 1 tablet, 2 capsules), units **SHOULD** contain the preferred name of the presentation units within braces { } using the units of presentation from the NCI Thesaurus

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[1] Several HITSP selected standards use different code systems for this data element. The HITSP Foundations Committee is working with the respective standards bodies to harmonize the standards. Until such time as harmonized standards are adopted, we recommend the use of a value set that is consistent with that specified by this constraint.

Identifier	Name	Definition	Constraints
8.09	Site	A Sig Component: The anatomic site where the medication is administered. Usually applicable to injected or topical products	C154-[DE-8.09-1] The Site **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.2.1 Body Site
8.10	Dose Restriction	A Sig Component: defines a maximum or dose limit. This segment can repeat for more than one dose restriction	
8.11	Product Form	The physical form of the product as presented to the patient. For example: tablet, capsule, liquid or ointment	C154-[DE-8.11-1] **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.3 Medication Product Form
8.12	Delivery Method	A Sig Component: A description of how the product is administered/consumed	

Table 2-25 Prescription & Non-Prescription Data Mapping - Definitions: Medication Information

Identifier	Name	Definition	Constraints
8.13	Coded Product Name	A code describing the product from a controlled vocabulary	C154-[DE-8.13-1] The coded product name **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.8 Medication Clinical Drug Names. C154-[DE-8.13-2] When only the class of the drug is known (e.g., Beta Blocker or Sulfa Drug), it **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.9 Medication Drug Class. C154-[DE-8.13-3] When only the medication ingredient name is know, the coded product name **MAY** be coded as specified in HITSP/C80 Section 2.2.3.3.11 Ingredient Name
8.14	Coded Brand Name	A code describing the product as a branded or trademarked entity from a controlled vocabulary	C154-[DE-8.14-1] The brand name **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.7 Medication Brand Name or 2.2.3.3.10 Medication Packaged Product.
8.15	Free Text Product Name	The name of the substance or product without reference to a specific vendor (e.g., generic or other non-proprietary name). If a Coded Product Name is present, this is the text associated with the coded concept	C154-[DE-8.15-1] This **SHOULD** be sufficient for a provider to identify a medication, and may include additional information such as strength, dose form, etc. If the name of the product is unknown, the type, purpose or other description may be supplied
8.16	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 associated with the coded concept	C154-[DE-8.16-1] This **MAY** include additional information such as strength, dose form, etc
8.17	Drug Manufacturer	The manufacturer of the substance or product as ordered or supplied. The distributor may be supplied if the manufacturer is not known	
8.18	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
8.19	Type of Medication	A classification based on how the medication is marketed (e.g., prescription, over the counter drug)	C154-[DE-8.19-1] The type of medication **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.5 Medication Type

Identifier	Name	Definition	Constraints
8.20	Status of Medication	If the medication is Active, Discharged, Chronic, Acute, etc	C154-[DE-8.20-1] The medication status **MAY** be recorded using the CCD Medication Status observation using the value set defined in the CCD
8.21	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	C154-[DE-8.21-1] The indication **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.1 Problem
8.22	Patient Instructions	Instructions to the patient that are not traditionally part of the Sig. For example, "keep in the refrigerator." More extensive patient education materials can also be included	
8.23	Reaction	Any noted intended or unintended effects of the product. For example: full body rash, nausea, rash resolved	
8.24	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 "Ampicillin 150mg in 50ml NS"; Aquaphor is the vehicle in "10% LCD in Aquaphor"	C154-[DE-8.24-1] The Vehicle shall be coded as specified in HITSP/C80 Section 2.2.3.3.12 Medication Vehicle
8.25	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"	

Table 2-26 Prescription & Non-Prescription Data Mapping - Definitions: Order Information

Identifier	Name	Definition	Constraints
8.26	Order Number	The order identifier from the perspective of the ordering clinician. Also known as the 'placer number' versus the pharmacies prescription number (or 'filler number')	
8.27	Fills	The number of times that the ordering provider has authorized the pharmacy to dispense this medication	
8.28	Quantity Ordered	The amount of product indicated by the ordering provider to be dispensed. For example, number of dosage units or volume of a liquid substance. Note: this is comprised of both a numeric value and a unit of measure	
8.29	Order Expiration Date/Time	The date, including time if applicable, when the order is no longer valid. Dispenses and administrations are not continued past this date for an order instance	
8.30	Order Date/Time	The date, including time if available, when the ordering provider wrote the order/prescription	
8.31	Ordering Provider	The person that wrote this order/prescription (may include both a name and an identifier)	
8.32	Fulfillment 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"	
8.33	Fulfillment History	History of dispenses for this order. Comprised of Fulfillment History Components	
8.34	Prescription Number	Fulfillment History Component: The prescription identifier assigned by the pharmacy	

Identifier	Name	Definition	Constraints
8.35	Dispensing Pharmacy (previously known as Provider)	Fulfillment History Component: The pharmacy that performed this dispense (may include both a name and an identifier)	
8.36	Dispensing Pharmacy Location (Previously known as Location)	Fulfillment History Component: The pharmacy's location	
8.37	Dispense Date	Fulfillment History Component: The date of this dispense	
8.38	Quantity Dispensed	Fulfillment History Component: The actual quantity of product supplied in this dispense. Note: This is comprised of both a numeric value and a unit of measure	
8.39	Fill number	Fulfillment History Component: The fill number for the history entry. Identifies this dispense as a distinct event of the prescription	
8.40	Fill Status	Fulfillment History Component. The fill event status is typically 'complete' indicating the fill event has been, or is expected to be picked up. A status of 'aborted' indicates that the dispense was never picked up (e.g., "returned to stock")	

2.1.2.9   PREGNANCY

This module contains information about the patient's current and historical pregnancy status.

Table 2-27 Pregnancy Data Mapping Table – Definitions

Identifier	Name	Definition	Constraints
9.01	Pregnancy	This is a simple observation that records whether the patient is currently pregnant	

2.1.2.10   INFORMATION SOURCE

This module describes information about the original author of the exchange and reference to source materials that can be provided in an exchange.

Table 2-28 Information Source Data Mapping Table – Definitions: Author

Identifier	Name	Definition	Constraints
10.01	Author Time	The time at which this information was created	
10.02	Author Name	The name of the person who created the information content	
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: Depending on the architectural variant applied, only references to documents which have been registered, so as to ensure that the registry/repository/system access control mechanisms are used to access these documents

Table 2-29 Information Source Data Mapping Table – Definitions: Information Source

Identifier	Name	Definition	Constraints
10.06	Information Source Name	The name of the person or organization that provided the information	

2.1.2.11 GENERAL PURPOSE DATA ELEMENTS

This collection of data elements applies to a variety of exchanges.

Table 2-30 General Purpose Data Mapping Table

Identifier	Name	Definition	Constraints
11.01	Free Text Comment	A free text comment that cannot be represented using existing data elements	
11.02	Reason	The reason given for a specific intervention or the reason it did not occur	
11.03	Tense	Tense is a modifier to a data element used to express time as it relates to a data element. For example, an event has occurred in the past or will occur in the future	

2.1.2.12 ADVANCE DIRECTIVE

This module contains data describing the patient's Advance Directive 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.

Table 2-31 Advance Directive Data Mapping Table – Definitions

Identifier	Name	Definition	Constraints
12.01	Advance Directive Type	This is a coded value describing the type of the Advance Directive	C154-[DE-12.02-1] The advance directive **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.10.1 Advance Directive Type
12.02	Advance Directive Free Text Type	Free text comment to describe the Advance Directive Type	
12.03	Effective Date	The effective date for the Advance Directive	
12.04	Custodian of the Document	Name, address or other contact information for the person or organization that can provide a copy of the document	

2.1.2.13 IMMUNIZATION

This module contains data describing the patient's immunization history.

Table 2-32 Immunizations Data Mapping Table – Definitions: Immunization Event Entry

Identifier	Name	Definition	Constraints
13.01	Refusal	A flag that the immunization event did not occur. The nature of the refusal (e.g., patient or patient caregiver refused, adverse reaction)	
13.02	Administered Date	The date and time of substance was administered or refused, i.e., when the immunization was administered to the patient, or refused by the patient or patient caregiver	
13.03	Medication Series Number	Indicate which in a series of administrations a particular administration represents (e.g. "Hepatitis B vaccine number 2")	

Identifier	Name	Definition	Constraints
13.04	Reaction	Any noted intended or unintended effects of the product. For example: full body rash, nausea, rash resolved	
13.05	Performer	The person that administered the immunization to the patient (may include both a name and an identifier)	

Table 2-33 Immunizations Data Mapping Table – Definitions: Medication Information

Identifier	Name	Definition	Constraints
13.06	Coded Product Name	A code describing the product from a controlled vocabulary	C154-[DE-13.06-1] Immunizations **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.5.1 Vaccines Administered.
13.07	Free Text Product Name	The name of the substance or product without reference to a specific vendor (e.g., generic or other non-proprietary name). If a Coded Product Name is present, this is the text associated with the coded concept	C154-[DE-13.07-1] This **SHOULD** be sufficient for a provider to identify a medication, and **MAY** include additional information such as strength, dose form, etc. If the name of the product is unknown, the type, purpose or other description **MAY** be supplied
13.08	Drug Manufacturer	The manufacturer of the substance or product as ordered or supplied. The distributor may be supplied if the manufacturer is not known	
13.09	Lot Number	The manufacturer's production lot number for the administered product	
13.10	Refusal Reason	When an immunization is refused, this provides a coded representation of the reason for refusing the immunization	C154-[DE-13.10-1] The reason for refusal **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.5.3 No Immunization Reason
13.11	Immunization Information Source	The immunization information source is a value which indicates where the information about a specific immunization record came from	C154--[DE-13.11-1] The Administration notes **SHALL** be coded using the HITSP/C80 Section 2.2.3.5.4 Immunization Information Source

2.1.2.14 VITAL SIGN

This module contains current and relevant historical vital signs for the patient. Vital Signs are a subset of Results (see Section 2.1.2.15), but are reported in this section to follow clinical conventions. The differentiation between Vital Signs and Results varies by clinical context. Common examples of vital signs include temperature, height, weight, blood pressure, etc. However, some clinical contexts may alter these common vital signs, for example in neonatology "height" may be replaced by "crown-to-rump" measurement.

Table 2-34 Vital Signs Data Mapping Table – Definitions

Identifier	Name	Definition	Constraints
14.01	Vital Sign Result ID	An identifier for this specific vital sign observation	
14.02	Vital Sign Result Date/Time	The biologically relevant date/time for the vital sign observation	
14.03	Vital Sign Result Type	A coded representation of the vital sign observation performed	C154-[DE-14.03-1] Vital signs **SHOULD** be coded as specified in HITSP/C80 Section 2.2.3.6.4 Vital Sign Result Type
14.04	Vital Sign Result Status	Status for this vital sign observation, e.g., complete, preliminary	
14.05	Vital Sign Result Value	The value of the result, including units of measure if applicable	
14.06	Vital Sign Result Interpretation	An abbreviated interpretation of the vital sign observation, e.g., normal, abnormal, high, etc	

Identifier	Name	Definition	Constraints
14.07	Vital Sign Result Reference Range	Reference range(s) for the vital sign observation	

2.1.2.15 RESULT

This module contains current and relevant historical result observations for the patient. The scope of "observations" is broad with the exception of "vital signs" which are contained in the Vital Signs sections (see Section 2.1.2.14 above).

Table 2-35 Results Data Mapping Table – Definitions: Result Event Entry

Identifier	Name	Definition	Constraints
15.01	Result ID	An identifier for this specific observation	
15.02	Result Date/Time	The biologically relevant date/time for the observation	
15.03	Result Type	A coded representation of the observation performed	C154-[DE-15.03-1] Result Type **SHOULD** be selected from LOINC (codeSystem 2.16.840.1.113883.6.1) or SNOMED CT (codeSystem 2.16.840.1.113883.6.96) C154-[DE-15.03-2] Result Type for laboratory results **SHOULD** be coded as specified in HITSP/C80 Section 2.2.3.6.1 Laboratory Observations
15.04	Result Status	Status for this observation, e.g., complete, preliminary	
15.05	Result Value	The value of the result, including units of measure if applicable	
15.06	Result Interpretation	An abbreviated interpretation of the observation, e.g., normal, abnormal, high, etc	C154-[DE-15.02-1] Result Interpretation **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.6.3 Result Normalcy Status
15.07	Result Reference Range	Reference range(s) for the observation	

2.1.2.16 ENCOUNTER

This module contains data describing the interactions between the patient and clinicians. Interaction includes both in-person and non-in-person encounters such as telephone and email communication.

Table 2-36 Encounters Data Mapping Table – Definitions: Encounter Event Entry

Identifier	Name	Definition	Constraints
16.01	Encounter ID	An identifier for this Encounter	
16.02	Encounter Type	This is a coded value describing the type of the Encounter	C154-[DE-16.02-1] Encounter Type **SHOULD** be coded as specified in HITSP/C80 Section 2.2.3.9.3 Encounter Type
16.03	Encounter Free Text Type	Free text describing the Encounter Type	
16.04	Encounter Date/Time	The date and time of the Encounter, including duration if pertinent	
16.05	Encounter Provider	Name and other information for the person or organization performed or hosted the Encounter	
16.06	Admission Source	Identifies where the patient was admitted	C154-[DE-16.06-1] The Admission Source **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.9.1 Admission Source
16.07	Admission Type	Indicates the circumstances under which the patient was or will be admitted	C154-[DE-16.07-1] The Admission Type **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.9.2 Admission Type

Identifier	Name	Definition	Constraints
16.08	Immunization Services Funding Eligibility	Immunization Services Funding Eligibility is a point in time marker for eligibility category that describes a person. The categories are specified by the federal Vaccines for Children program. It does not refer to who actually paid for a given immunization	
16.09	Discharge Disposition	Discharge Disposition (sometimes called "Discharge Status") is the person's anticipated location or status following the encounter (e.g. death, transfer to home/hospice/SNF/AMA) – uses standard claims-based codes	C154-[DE-16.09-1] The Discharge Disposition **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.9.4 Discharge Disposition
16.10	Patient Class	This is used to categorize patients by the site where the encounter occurred , e.g., Emergency, Inpatient, or Outpatient	C154-[DE-16.10-1] Patient Class SHALL be coded as specified in HITSP/C80 Section 2.2.3.9.5 Patient Class
16.11	In Facility Location	The service delivery location	
16.12	Arrival Date/Time	The date and time the patient arrived at the location	
16.13	Reason for Visit	Indicates the rationale for the encounter	
16.14	Order to Admit Date/Time	The date and time the provider has ordered that the patient be admitted	
16.15	Decision to Admit Date/Time	The date and time the provider decided to admit the patient	
16.16	Discharge Date/Time	The date and time of the patient discharge	
16.17	Facility ID	The identifier used to identify the facility. If a National Facility Identifier is used, this is a unique identification number, including when necessary the assigning authority, issued to healthcare facilities in the United States	
16.18	Facility Name	The name of the facility where the encounter occurred	
16.19	Facility Address	The address of the facility where the encounter occurred	C154-[DE-16.19-1] The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State C154-[DE-16.19-2] The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code C154-[DE-16.19-3] The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country
16.20	In Facility Location Duration	The duration for which a patient is at a specific location	

2.1.2.17 PROCEDURE

This module contains a coded entry indicating a procedure performed on a patient.

Table 2-37 Procedure Data Mapping Table – Definitions

Identifier	Name	Definition	Constraints
	Procedures	The Continuity of Care Document (CCD) section where procedures the patient has undergone are described	
17.01	Procedure ID	An identifier for this Procedure	

Identifier	Name	Definition	Constraints
17.02	Procedure Type	This is a coded value describing the type of the Procedure	
17.03	Procedure Free Text Type	Free text describing the Procedure	
17.04	Procedure Date/Time	The date and time of the Procedure, including duration if pertinent	
17.05	Procedure Provider	Name and other information for the person or organization performed or hosted the Procedure	
17.06	Body Site	The anatomical site where a procedure is performed	C154-[DE-17.06-1] The Site **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.2.1 Body Site

2.1.2.18 FAMILY HISTORY

This module contains data defining the patient's genetic risk factors.

Table 2-38 Family History Data Mapping Table – Definitions

Identifier	Name	Definition	Constraints
18.01	Pedigree	A pedigree is a graphic, visual presentation of a family's health history and genetic relationships for the purpose of health risk assessment. It can provide a mechanism to identify the distribution of a medical condition or a related condition in a group of close relatives. If the condition or related condition clusters among relatives or follows a clear pattern of inheritance, then the risk for the condition can be assessed for the unaffected family members. It is important that the structured data from which the pedigree is derived also be present, because identification of inherited conditions can be complex requiring clinical decision support algorithms	
18.02	Family Member Information	Family member information, including demographic data, health history, genetic test results, and relationships to other family members	
18.03	Family Member Demographics	Demographic information for the family member	

Identifier	Name	Definition	Constraints
18.04	Family Member Relationship	Relationship of Family Member to Patient or other Family Member. Record information on relatives including 1st and 2nd degree, such as: • Mother • Siblings • Children • Aunts/uncles • Cousins • Grandchildren • Nieces/Nephews This data element also allows the recording of the natural father and mother, and the adoptive status. Consanguinity can be determined by including relationships between consanguineous individuals. Note: In order to record information for 3rd degree relatives and beyond, implementations can provide recursive entries. For example, the first entry could state a "grandmother", then the next entry could state the "grandmother's mother" which would be a 3rd degree relative. This enables any degree on relatives	C154-[DE-18.04-1] The Family Member Relationship (to Patient) **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.5 Family Relationship Type
18.05	Family Member Relationship Free Text	Free Text Data Entry for each relative used to note special cases. Examples include gamete donor and/or surrogate mother	
18.06	Family Member Identifier	An identifier used to track the family member in communications between systems	
18.07	Family Member Name	The name of the Family Member, used to distinguish family members textually, and need not be the actual legal name of the family members	
18.08	Family Member Date of Birth	Date of Birth of Family Member	
18.24	Family Member Administrative Gender	The Administrative Gender is used to refer to administrative sex rather than biological sex and therefore should easily be classified into female and male. Biological sex is recorded separately when necessary	C154-[DE-18.24-1] Gender **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.1 Administrative Gender
18.09	Family Member Race	Race is usually a single valued term that may be constant over that patient's lifetime. The coding of race is aligned with public health and other Federal reporting standards of the CDC and the Census Bureau	C154-[DE-18.09-1] Race **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.7 Race
18.10	Family Member Ethnicity	Ethnicity is a term that extends the concept of race. The coding of ethnicity is aligned with public health and other Federal reporting standards of the CDC and the Census Bureau	C154-[DE-18.10-1] Ethnicity **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.2 Ethnicity
18.11	Family Member Medical History	Information including current and past problems the family member, and genetic test results	
18.12	Family Member Condition	Condition is the generic term used in the model to designate conditions, problems, diagnoses, etc	C154-[DE-18.12-1] The problem type **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.2 Problem Type. C154-[DE-18.12-2] The problem **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.1 Problem

Identifier	Name	Definition	Constraints
18.23	Family Member Age	The real or approximate age of the family member	
18.13	Family Member Age (at Onset)	The age (real or approximate) of the family member at the onset of the illness	
18.14	Family Member Cause of Death	An indicator that a particular problem was the cause of death of the family member	
18.15	Family Member Age (at Death)	The age (real or approximate) of the family member at death	
18.16	Family Member Biological Sex	The biological sex of the Family Member. To be used when Administrative Sex (male/female) is not adequate to describe the family member's sex	
18.17	Family Member Multiple Birth Status	Specifies if the family member is a twin, triplet etc and whether identical or fraternal	
18.18	Family Member Genetic Test Information	Information about genetic test results for family members	C154-[DE-18.18-1] Components of a Genetic Laboratory Test **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.11 Genetic Testing
18.19	Family Member Genetic Test Code	The code for the genetic lab test	
18.20	Family Member Genetic Test Name	The name of the genetic lab test	
18.21	Family Member Genetic Test Result	The result produced by the genetic lab test	
18.22	Family Member Genetic Test Date	The date of the genetic lab test	
18.23	Family Member Age	The real or approximate age of the family member	
18.26	Family Member Multiple Birth Order	Indicates the ordinal position of the family member in their order of birth in a multiple birth	
18.25	Family Member Problem Status	The status of the family member's problem (i.e., Active, Inactive, Resolved)	C154-[DE-18.23-1] The problem **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.8 Problem Status

2.1.2.19 SOCIAL HISTORY

The text adapted from HL7 CDA Release 2 - Continuity of Care Document (CCD), Section 3.7 Social History, begins here:

This module contains data defining the patient's occupational, personal (e.g. lifestyle), social, and environmental history and health risk factors, as well as administrative data such as marital status, race, ethnicity and religious affiliation.

The text adapted from HL7 CDA Release 2 - Continuity of Care Document (CCD), Section 3.7 Social History, ends here.

Table 2-39 Social History Data Mapping Table – Definitions: Social History Event Entry

Identifier	Name	Definition	Constraints
19.01	Social History Date	This is the range of time of which the social history event was active for the patient or subject	

Identifier	Name	Definition	Constraints
19.02	Social History Type	This is a coded value indicating the type of social history observation	C154-[DE-19.02-1] The Social History type **SHALL** be coded as specified in HITSP/C80 Section 2.2.2.4 Social History Type
19.03	Social History Free Text	This is a text description of the social history	
19.04	Social History Observed Value	A value describing the social history	

2.1.2.20 MEDICAL EQUIPMENT

Medical Equipment includes implanted and external medical devices and equipment that a patient's health status depends on, as well as any pertinent equipment or device history.

The definition of this Module is for future development.

2.1.2.21 FUNCTIONAL STATUS

The functional status module contains data defining the patient's functional status with respect to Ambulatory ability, Mental status or competency, Activities of Daily Living, including bathing, dressing, feeding, grooming, Home/living situation having an effect on the health status of the patient or their Ability to care for themselves.

The definition of this Module is for future development.

2.1.2.22 PLAN OF CARE

The plan of care contains data defining prospective or intended orders, interventions, encounters, services, and procedures for the patient.

Table 2-40 Plan of Care Data Mapping Table – Definitions

Identifier	Name	Definition	Constraints
22.01	Discharge Instructions	Discharge instructions provide the patient with education on expected progression of illness or injury, treatment and care use of medications and follow-up	

2.1.2.23 CLINICAL RESEARCH

The clinical research module contains data defining data elements and common identifier variables that pertain to research-specific workflow.

Table 2-41 Clinical Research Data Mapping Table – Definitions

Identifier	Name	Definition	Constraints
23.01	Sponsor ID	A unique identifier for a Protocol Sponsor or Study Sponsor taking responsibility for the clinical research, The Sponsor may be an individual, a company, an institution or organization	
23.02	Protocol Study ID	A unique identifier for a clinical research study within a submission	
23.03	Study Site ID	A unique identifier for the clinical research site for a given clinical study. This identifier is not unique outside of the context of a given clinical research study	
23.04	Investigator ID	A unique identifier for the clinical researcher who oversees all aspects of the study at the study site	

2.1.2.24 ORDER

This module contains data defining the patient's order.

Table 2-42 Order Data Mapping

Identifier	Name	Definition	Constraints
24.01	Order Group Number	An order group is a list of orders associated with an - placer group number. A group is established when the placer supplies a placer group number with the original order	
24.02	Order Status	Report the status of an order either upon request or when the status changes	
24.03	Parent Order Number	The Order number of the Parent Order which may have spawned Child orders. Used to maintain the original connection of the original order	
24.04	Date Time of Transaction	The date and time of the order transaction	
24.05	Order Entered By	The identity of the person who actually keyed the request into the order application (may include both a name and/or an identifier)	
24.06	Order Verified By	The identity of the person who verified the accuracy of the entered request (may include both a name and/or an identifier)	
24.07	Order Setting Type	Indicates the care setting in which the order is executed	
24.08	Requested Order Start Date/Time	The date/time when the ordering provider is requesting the execution of orders	
24.09	Order Priority	The priority of the order	
24.10	Placer Order Number	The order identifier from the perspective of the system placing the order	
24.11	Filler Order Number	The order identifier from the perspective of the system fulfilling the order	
24.12	Order Code	The order code for the requested observation, test, and/or battery. Note: This can be based on local and/or standardized order codes	
24.13	Specimen Action	Identifies the action to be taken with respect to the specimens that accompany or precede this order. The purpose of this field is to further qualify (when appropriate) the general action indicated by the order	
24.14	Ordering Provider	The person that wrote this order (may include both a name and an identifier)	
24.15	Results Distribution List	Identifies the people and/or organization that are to receive copies of the results	
24.16	Specimen Collector ID	The person, department, or facility that collected the specimen. (may include both a name and an identifier)	

2.1.2.25 SPECIMEN

This module contains data defining the Specimen related to an Order.

Table 2-43 Specimen Data Mapping Table

Identifier	Name	Definition	Constraints
25.01	Specimen ID	An identifier for this specific Specimen	
25.02	Specimen Parent ID	The identifiers for the specimen or specimens that contributed to the specimen	
25.03	Specimen Type	The precise nature of the specimen observed/received	
25.04	Specimen Collection Method	Describes the procedure or process by which the specimen was collected	
25.05	Specimen Source Site	Specifies the source from which the specimen was obtained. For example, in the case where a liver biopsy is obtained via a percutaneous needle, the source would be 'liver'	
25.06	Specimen Source Site Modifier	Modifies or qualifies description(s) about the specimen type	
25.07	Specimen Risk	Describes any known or suspected specimen hazards, e.g., exceptionally infectious agent or blood from a hepatitis patient	
25.08	Specimen Collection Date/Time	The date and time when the specimen was acquired from the source. The use of the Date Range data type allows for description of specimens collected over a period of time, for example, 24-hour urine collection	
25.09	Specimen Received Date/Time	The date/time that the specimen is received at the diagnostic service	
25.10	Specimen Availability	Describes whether the specimen, as it exists, is currently available to use in an analysis	
25.11	Specimen Rejection Reason	Describes a reason for which the specimen is being rejected for the specified observation/result/analysis	
25.12	Number of Specimen Containers	The number of containers for a given sample. (For sample receipt verification purposes; this may be different from the total number of samples that accompany the order)	

2.2   QUALITY DOMAIN DATA MAPPING

2.2.1   QUALITY DATA DICTIONARY

In the initial evaluation of the Quality Use Case, HITSP identified a need for a quality dataset and was directed to the National Quality Forum (NQF) as a consensus-based organization with transparent processes as a continuous source for quality data elements based on the Health Information Technology Expert Panel (HITEP). HITEP was convened by NQF under a grant from the Agency for Healthcare Research and Quality (AHRQ) to establish a data framework for quality measurement, the Quality Data Set (QDS). HITSP has been using the HITEP as the ongoing source for the quality data requirements to inform the HITSP Quality Interoperability Specification. The QDS uses the term data type to indicate information found in electronic records bound to the context of use (e.g. medication administered, medication allergy, medication ordered). HITSP has previously looked to the output of the first HITEP report. This section reflects the most recent model created by the HITEP. The following table includes data element and information requirements for quality measurement derived from the list of quality data types provided by HITEP.

The following concepts may evolve over time as new care models emerge. The intent of this chart is to identify how these concepts will flow from definition to HITSP constrained reference standards. Some

quality data types could not be identified in HITSP constrained standards, and either represent gaps or harmonization requirements for the future.

Table 2-44 Data Elements Cross Reference

Column	Definition
HITEP II Standard Element	This column contains the HITEP II Standard Element
HITEP II Quality Data Element	This column contains the HITEP II Quality Data Element
HITEP II Definition	This column reflects the definitions associated with the data element
HITSP Data Element Definition	The HITSP Data Element that corresponds to the HITEP II Data Element. This is the numeric identifier and name of the data element from HITSP/C154 - Data Dictionary
HITSP/C83 – CDA Content Modules Mapping	The numeric identifier and name of the HITSP/C83 – CDA Content Modules section corresponding to the HITEP II Data Element
HL7 Message	This column indicates where the data element is communicated in HL7 messaging
Additional Specifications	Specifies additional HITSP constraints for use with HITEP II Quality Data Elements, as well as other information that may be pertinent

Unless followed by an alternate source indication in parenthetical notation, the 'SDO Identifier and Name' column in the following table is from HITEP II: Data element name/identifier as listed by the American Health Information Community Expert Panel for the Identification of Core Data Elements and Prioritization of AQA and HQA Performance Measures for Electronic Healthcare Information Systems

In addition to the data elements listed below, Quality Measures may rely on additional derived attributes that reflect interpretation or computation of information based upon the data elements listed below.

Table 2-45 HITEP II Data Mapping

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
Care experience	Patient care experience	Care experience is measured most often with a validated survey tool. The most common tool is the Consumer Assessment of Healthcare Providers and Systems (CAHPS - details available at: https://www.cahps.ahrq.gov/default.asp)	GAP	GAP	GAP	
Care experience	Provider care experience	Provider care experience gauges provider satisfaction with key processes in the healthcare delivery system. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to garner quantifiable data on provider satisfaction with the performance of Medicare fee-for-service contractors.[3] Most care experience surveys are local. Provider care experience is a factor in provider turnover	GAP	GAP	GAP	NOTE: Example of provider care experience: Structural measure on how long it takes to enter problem list data
Care goal	Care goal	A goal is a defined target or measure to be achieved in the process of patient care. A typical goal is expressed as an observation scheduled for some time in the future with a particular value	RESULT EVENT ENTRY 15.01 Result ID 15.02 Result Date/Time 15.03 Result Type 15.04 Result Status 15.05 Result Value 15.06 Result Interpretation 15.07 Result Reference Range 11.03 Tense	2.2.1.24 PLAN OF CARE (Under development – attributes not yet available)	GOL Goal Detail Segment	For C83, 11.03 Tense **SHALL** be 'GOL'
		NOTE: The plan of care (care plan) is the structure used by all stakeholders, including the patient, to define the management actions				

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[2] May have constraints that identify "Limit/Range of values", Data Source, and/or "Requirements/Pre-conditions"

[3] Medicare Contractor Provider Satisfaction Survey (MCPSS). Information available at: http://www.cms.hhs.gov/MCPSS/.

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		for the various conditions, problems, or issues identified for the target of the plan. It is the structure through which the goals and care planning actions and processes can be organized, planned, communicated, and checked for completion Specifically, a care plan is composed of the following elements: "Problem" is another data type "Intervention" may be a procedure, medication, substance… (Any data type that is an action). The "goal" is what is expected to happen. The "outcome" is what happened which can be shown by other data types				
Communication	Communication provider to provider	The provision of any communication from one clinician to another regarding findings, assessments, plans of care, consultative advice, instructions, educational resources, etc.	GAP	GAP - Need to be able to deal with any communication. This needs to also address ambulatory and all other encounter settings (e.g. telephone communication, electronic communication)	GAP	SEE GAP: As a Derived Element Refer to the procedure section for procedure occurrence and result
Communication	Communication from patient	Receive response from a patient with respect to any aspect of the care provided	GAP	GAP - Need to be able to deal with any communication. This needs to also address ambulatory and all other encounter settings (e.g. telephone communication,	GAP	e.g. May be nursing that patient verbalizes/demonstrates understanding of instruction

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
				electronic communication)		
Communication	Communication to patient	Providing any communication to the patient. E.g., results, findings, plans for care, medical advice, instructions, educational resources, appointments, results, etc	For Discharge Instructions: PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site For other communications: GAP	For Discharge Instructions 2.2.2.17 Procedure: 17.01 Procedure Performed For other communications: GAP - Need to be able to deal with any communication. This needs to also address ambulatory and all other encounter settings (e.g. telephone communication, electronic communication)	GAP	For CDA, NOTE: Likely to be text in existing systems, some may be codified in nursing terminologies which can be mapped to SNOMED
Condition/ diagnosis/ problem		HITEP II Definition: (NOTE – general definition; applies to all Diagnosis quality data types to follow) A problem, diagnosis or condition is a scientific interpretation of result, assessment and treatment response data that persists over time and tends to require intervention or management. It is used to guide planning, implementation, treatment and evaluation. A problem or condition includes, but is not limited to chronic conditions, diagnoses, or symptoms, functional limitations, or visit or stay-specific conditions				
Condition/diagn osis/ problem	Diagnosis, active	A problem, diagnosis or condition that is currently monitored, tracked or is a factor that must be	PROBLEM ENTRY 7.01 Problem Date 7.02 Problem Type	2.2.2.7 CONDITION 2.2.1.3 PROBLEM LIST	PPR Patient Problem Message; PRB Problem Detail	For CDA, Constraint: 7.12 Problem status **SHALL** = active

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		considered as part of the treatment plan in progress	7.03 Problem Name 7.04 Problem Code 7.05 Treating Provider 7.06 Age (at Onset) 7.07 Cause of Death 7.08 Age (at Death) 7.09 Time of Death 7.10 Diagnosis Priority 7.11 Treating Provider ID 7.12 Problem Status		Segment	NOTE: For CDA and Messaging, Problem needs to be identified as patient-level, encounter-level; active or inactive. Need to reflect the concept of 'present on admission' Need an appropriate problem model used across the board to be able to include active/inactive patient-level/encounter-level, etc. Vocabulary **SHALL** be used to indicate that the problem is active
Condition/diagnosis/problem: diagnosis,	Diagnosis, factored Risk	Potential for development of problems or conditions determined by specific factors defined within the measure by the measure developer. Most often these risks can be defined as a composite of several QDS elements that, based on evidence, in combination represent a risk of a specific condition or negative outcome		Derived attribute – don't model	Derived attribute – don't model	
Condition/diagnosis/problem diagnosis	Diagnosis, family History	Problems, conditions and diagnoses existing currently or in the past for a patient's family members	CONDITION: (Data Elements As Above) FAMILY HISTORY SECTION 18.01 Pedigree 18.02 Family Member Information 18.03 Family Member Demographics 18.04 Family Member Relationship (to Patient) 18.05 Family Member Relationship Free Text Family Member Person Information	2.2.1.25; 2.2.2.18 FAMILY HISTORY 2.2.2.7 CONDITION 2.2.1.3 PROBLEM LIST	PPR – Patient Problem Message	Vocabulary **SHALL** be used to constrain the problem to family history

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
			18.06 Family Member Identifier 18.07 Family Member Name 18.08 Family Member Date of Birth 18.24 Family Member Administrative Gender 18.09 Family Member Race 18.10 Family Member Ethnicity 18.11 Family Member Medical History 18.12 Family Member Condition 18.13 Family Member Age (at Onset) 18.14 Family Member Cause of Death 18.15 Family Member Age (at Death) 18.16 Family Member Biological Sex 18.17 Family Member Multiple Birth Status 18.23 Family Member Age 18.18 Family Member Genetic Test Information 18.19 Family Member Genetic Test Code 18.20 Family Member Genetic Test Name 18.21 Family Member Genetic Test Result 18.22 Family Member Genetic Test Date			
Condition/diagnosis/problem	Diagnosis, past history	Problems, conditions and diagnoses that have occurred in the past for the patient under treatment	2.1.2.7 CONDITION (Data Elements As Above)	2.2.2.7 CONDITION 2.2.1.3 PROBLEM LIST 2.2.1.4 HISTORY OF PAST ILLNESS 2.2.1.7 HISTORY OF PRESENT ILLNESS	PPR – Patient Problem Message	NOTE: Problem needs to be identified as patient-level, encounter-level, active or inactive. Need to reflect the concept of 'present on admission'. Need an appropriate problem model used across the board to be able to include active/inactive patient-level/encounter-level, etc

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
						Vocabulary shall be used to indicate past history of diagnosis
Condition/diagnosis/problem	Diagnosis, risk-of	Potential for development of problems or conditions determined by a risk calculator scale. Examples: Braden Score for Predicting Pressure Sore Risk, Morse Fall Risk Scale, Pneumonia Severity Index** ** Available at: http://pda.ahrq.gov/clinic/psi/psicalc.asp	2.1.2.7 CONDITION (Data Elements As Above) COMMENT 11.03 Tense	2.2.2.7 CONDITION 2.2.1.3 PROBLEM LIST	PPR – Patient Problem Message DG1 Diagnosis Segment	For CDA, Constrain 11.03 Tense: - HL7 ACT Mood = "Risk" (RSK v:ActMoodRisk), OR use a SNOMED code for Risk - (Alternative: use post-coordinated SNOMED expressions as the representation) NOTE: Problem needs to be identified as patient-level, encounter-level, active or inactive. Need to reflect the concept of 'present on admission'. Need an appropriate problem model used across the board to be able to include active/inactive patient-level/encounter-level, etc
Device		HITEP II Definition: (NOTE: General definition applies to all Device quality data types to follow). Device has been defined by the Food and Drug Administration (FDA), Department of Health and Human Services. A device is "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a				

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		component part, or accessory which is: Recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes." This definition provides a clear distinction between a medical device and other FDA-regulated products such as drugs. If the primary intended use of the product is achieved through chemical action or by being metabolized by the body, the product is usually a drug				
Device	Device, adverse event	In the instance of a quality measure, a device adverse event is an unexpected or dangerous reaction to a device. Serious adverse events are those that are fatal, life-threatening, permanently/significantly disabling, those that require or prolong hospitalization, and those that require intervention to prevent permanent impairment or damage. A date/time stamp is required as are notations indicating whether item is patient reported and/or provider	ADVERSE EVENT ENTRY 6.01 Adverse Event Date 6.02 Adverse Event Type Product Product Detail 6.03 Product Free-Text 6.04 Product Coded Reaction 6.05 Reaction Free-Text 6.06 Reaction Coded Severity 6.07 Severity Free-Text 6.08 Severity Coded	2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS 2.2.2.6 ALLERGY/DRUG SENSITIVITY 2.2.1.28 MEDICAL EQUIPMENT (under development)	IAM Adverse Reaction Information	NOTE: Vocabulary OVERLAP for device identifier associated with adverse event NOTE: Vocabulary OVERLAP for expressing device identifier in "Product Coded"; proposed data elements for addition: Device identifier Device model number Device serial number

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		verified				Device manufacturer
Device	Device, allergy	A device allergy is an immunologically medicated reaction that exhibits specificity and recurrence on re-exposure to the offending device (e.g. implanted device). A date/time stamp is required as are notations indicating whether the item is patient reported and/or provider verified	ADVERSE EVENT ENTRY 6.01 Adverse Event Date 6.02 Adverse Event Type Product Product Detail 6.03 Product Free-Text 6.04 Product Coded Reaction 6.05 Reaction Free-Text 6.06 Reaction Coded Severity 6.07 Severity Free-Text 6.08 Severity Coded	GAP: Modeling gap to reflect device as the participation type 2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS 2.2.2.6 ALLERGY/DRUG SENSITIVITY 2.2.1.28 MEDICAL EQUIPMENT (under development)	AL1 – Allergy Segment	Manufacturing: Device Allergy is in label detail. NOTE: Vocabulary OVERLAP for device identifier associated with allergy NOTE: Vocabulary OVERLAP for expressing device identifier in "Product Coded"; proposed data elements for addition: Device identifier Device model number Device serial number Device manufacturer See Gaps
Device	Device, applied	Indication that equipment designed to treat, monitor or diagnose a patient's status is in use. (e.g. in a venous thromboembolism measure is that an antithrombotic device has been placed on the patient's legs to prevent thromboembolism)	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site	2.2.1.28 MEDICAL EQUIPMENT (under development) 2.2.2.17 PROCEDURE 2.2.1.8 LIST OF SURGERIES (under development) Procedure note Nursing notes device configuration information; CDA representation in PMHR (see HITSP/C74) Needs to be added to HITSP/C83 See Vocabulary Overlap	Pharmacy/Treatment Administration Segment (RXA) NOTE: Used where treatment is a device	NOTE: Handle as a "Procedure" and identify the "Device" used in the procedure See GAP: General Structured Document for Operative Note – section on surgical procedures, but this only covers surgically-installed devices NOTE: Vocabulary OVERLAP for expressing device identifier in "Product Coded"; proposed data elements for addition: Device identifier Device model number

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
						Device serial number Device manufacturer
Device	Device, declined	Equipment designed to treat, monitor or diagnose a patient's status has been declined	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site COMMENT 11.03 Tense	2.2.1.28 MEDICAL EQUIPMENT (under development) 2.2.2.17 PROCEDURE 2.2.1.8 LIST OF SURGERIES 2.2.2.11 Comment	GAP NOTE: For HL7 messaging, Order management workflow – there was an order and status is cancelled – Order Status – Action item to work on Lab orders construct – relies on HL7 orders – controlled vocabulary terms	NOTE: Proposed to include in the definition the following – This may also include the scenario where the device is ordered but is not completed because it was not scheduled, cancelled, not tolerated, rescinded, no-show, equipment /system failure due to "Reason(s)" listed in the Constraints For CDA, Constrain 11.03: HL7 ActMood = INT negation IND = True has Reason where HL7 ActReason (see below) -- 3 categories: PATIENT REASON MEDICAL REASON SYSTEM REASON NOTE: If used HL7 Act Mood constraints, then handle as a "Procedure" and identify the "Device" used in the procedure See OVERLAPs for expression of ActReason See GAPs for classification of

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
						ActReason into: PATIENT REASON MEDICAL REASON SYSTEM REASON See GAP: General Structured Document for Operative Note – section on surgical procedures, but this only covers surgically-installed devices

Device	Device, intolerance	Device intolerance is a reaction in specific patients representing a low threshold to the normal actions of a device. Side effects experienced do not represent adverse events or allergies. A date/time stamp is required as are notations indicating whether the item is patient reported and/or provider verified	ADVERSE EVENT ENTRY
			  6.01 Adverse Event Date
			  6.02 Adverse Event Type
			Product
			Product Detail
			  6.03 Product Free-Text
			  6.04 Product Coded
			Reaction
			  6.05 Reaction Free-Text
			  6.06 Reaction Coded
			Severity
			  6.07 Severity Free-Text
			  6.08 Severity Coded
			May also be indicated in:
			PROBLEMS and Post-Coordinated SNOMED Codes:
			2.1.2.7 CONDITION (Data Elements As Above)
				2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS
				2.2.2.6 ALLERGY/DRUG SENSITIVITY
				2.2.1.28 MEDICAL EQUIPMENT (under development)
				May also be indicated in:
				2.2.2.7 CONDITION
				2.2.1.3 PROBLEM LIST Using post-coordinated SNOMED Concepts
					OBX - Observation	NOTE: HITSP "2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS" Section contains elements that allow the distinction between allergy and intolerance
						GAP: Vocabulary for Adverse Event Type of Device Intolerance
						NOTE: Vocabulary OVERLAP for device identifier associated with intolerance
						NOTE: Vocabulary OVERLAP for expressing device identifier in "Product Coded"; proposed data elements for addition:
						Device identifier
						Device model number
						Device serial number
						Device manufacturer

Device	Device, offered	Equipment designed to treat, monitor or diagnose a patient's	GAP for device orders; Interim approach:	2.2.1.28 MEDICAL EQUIPMENT (under	GAP	For CDA, Constrain 11.03:

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		status is offered to the patient	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site COMMENT 11.03 Tense	development) 2.2.2.17 PROCEDURE 2.2.1.8 LIST OF SURGERIES (under development) 2.2.2.11 Comment		HL7 Act Mood = INT - where INT (intent) 10199 NOTE: Vocabulary OVERLAP for device identifier associated with device offered. NOTE: Vocabulary OVERLAP for expressing device identifier in "Product Coded"; proposed data elements for addition: Device identifier Device model number Device serial number Device manufacturer
Device	Device, order	Equipment designed to treat, monitor or diagnose a patient's status is ordered	GAP for device orders; Interim approach: PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site COMMENT 11.03 Tense	2.2.1.28 MEDICAL EQUIPMENT (under development) 2.2.2.17 PROCEDURE 2.2.1.8 LIST OF SURGERIES (under development) 2.2.2.11 Comment	RXO - Pharmacy/Treatment Order Segment Used for devices requiring a prescription GAP - Non-prescription devices	For CDA, Constrain 11.03: HL7 Act Mood = RQO - where RQO (Request) NOTE: Need to capture summary of devices ordered (and not the order itself). In the care plan is the list of things the provider intended to be done; in INT mood, orders are typically handled through a separate process and do not show up in the summary. NOTE: Vocabulary OVERLAP for device identifier associated with device ordered

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
						NOTE: Vocabulary OVERLAP for expressing device identifier in "Product Coded"; proposed data elements for addition: Device identifier Device model number Device serial number Device manufacturer
Diagnostic study	Diagnostic study, adverse event	In the instance of a quality measure, a diagnostic study adverse event is an unexpected or dangerous reaction to a diagnostic study. Serious adverse disabling, those that require or prolong hospitalization, and those that lead to congenital anomaly or require intervention to prevent permanent impairment or damage. A time/date stamp is required, as are notations indicating whether item is patient reported and/or provider verified	ADVERSE EVENT ENTRY 6.01 Adverse Event Date 6.02 Adverse Event Type Product Product Detail 6.03 Product Free-Text 6.04 Product Coded Reaction 6.05 Reaction Free-Text 6.06 Reaction Coded Severity 6.07 Severity Free-Text 6.08 Severity Coded	2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS 2.2.2.6 ALLERGY/DRUG SENSITIVITY	IAM Adverse Reaction Information	
Diagnostic study	Diagnostic study, declined	A diagnostic study has been declined. NOTE: Proposed to include in the definition the following. This may also include the scenario where the diagnostic study is ordered but is not completed because it was not scheduled, cancelled, not tolerated, rescinded, no-show, equipment /system failure due to "Reason(s)" listed in the Constraints	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site COMMENT 11.03 Tense	2.2.2.17 PROCEDURE 2.2.2.11 Comment	GAP NOTE: For HL7 messaging, Order management workflow – there was an order and status is cancelled – Order Status – Action item to work on Lab orders construct – relies on HL7 orders – controlled vocabulary terms	For CDA, Constrain 11.03: HL7 ActMood = INT negation IND = True has Reason HL7 ActReason -- 3 categories: PATIENT REASON MEDICAL REASON SYSTEM REASON See OVERLAPs for expression of ActReason See GAPs for classification of ActReason into:

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
						PATIENT REASON MEDICAL REASON SYSTEM REASON
Diagnostic study	Diagnostic study, intolerance	Diagnostic study intolerance is a reaction in specific patients representing a low threshold to the normal reported or expectation reactions of the study. Side effects experienced do not represent adverse events or allergies. A time/date stamp is required, as are notations indicating whether the item is patient reported and/or provider verified	ADVERSE EVENT ENTRY 6.01 Adverse Event Date 6.02 Adverse Event Type Product Product Detail 6.03 Product Free-Text 6.04 Product Coded Reaction 6.05 Reaction Free-Text 6.06 Reaction Coded Severity 6.07 Severity Free-Text 6.08 Severity Coded	2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS 2.2.2.6 ALLERGY/DRUG SENSITIVITY	OBX - Observation	Adverse Event Type shall indicate intolerance. GAP – Intolerance type other than medication and food is not currently defined in HITSP/C80
Diagnostic study	Diagnostic study offered	An offer or suggestion to a patient for a diagnostic study. Diagnostic studies are those that are not performed in the clinical laboratory. Such studies include but are not limited to imaging studies, cardiology studies (electrocardiogram, treadmill stress testing), pulmonary function testing, vascular laboratory testing, and others	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site COMMENT 11.03 Tense	2.2.2.17 PROCEDURE 2.2.2.11 Comment 2	GAP	For CDA, Constrain 11.03: HL7 ActMood = INT where INT (intent) 10199
Diagnostic study	Diagnostic study order	A request by a physician or appropriately licensed care provider to an appropriate provider or facility to perform a diagnostic on a patient. The request may be in the form of a consultation or a direct order to the facility or organization that performs the diagnostic study. Diagnostic studies are those that are not performed in the clinical laboratory. Such studies include but are not limited to imaging studies, cardiology studies	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site RESULT EVENT ENTRY 15.01 Result ID 15.02 Result Date/Time 15.03 Result Type 15.04 Result Status 15.05 Result Value	2.2.1.22 DIAGNOSTIC RESULTS SECTION (refers to IHE Coded Section, C83 Procedure module, and C83 Result module) 2.2.2.17 PROCEDURE 2.2.2.15 RESULT NOTE: Resulted procedure is part of	ORU Unsolicited transmission of an observation message – OBR - Observation Request Segment NOTE: Also available from HITSP/C41	For CDA, Constrain 11.03: NOTE: Procedures in "Request" mood HL7 ActMood = RQO RQO (request) 19973

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		electrocardiogram, treadmill stress testing), pulmonary function testing, vascular laboratory testing, and others	15.06 Result Interpretation 15.07 Result Reference Range COMMENT 11.03 Tense	the results entry 2.2.2.11 Comment		
Diagnostic study	Diagnostic study performed	A diagnostic study has been completed. Diagnostic studies are those that are not performed in the clinical laboratory. Such studies include but are not limited to imaging studies, cardiology studies (electrocardiogram, treadmill stress testing), pulmonary function testing, vascular laboratory testing, and others	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site RESULT EVENT ENTRY 15.01 Result ID 15.02 Result Date/Time 15.03 Result Type 15.04 Result Status 15.05 Result Value 15.06 Result Interpretation 15.07 Result Reference Range	2.2.1.22 DIAGNOSTIC RESULTS SECTION (refers to IHE Coded Section, HITSP/C83 Procedure module, and HITSP/C83 Result module) 2.2.2.15 RESULT 2.1.2.16; 2.2.2.17 PROCEDURE	ORU Unsolicited transmission of an observation message	NOTE: Diagnostic study performed is available in the resulted test as well as in the list of procedures performed
Diagnostic study	Diagnostic study result	The result, described in concepts or numerical values of a diagnostic on a patient. Diagnostic studies are those that are not performed in the clinical laboratory. Such studies include but are not limited to imaging studies, cardiology studies (electrocardiogram, treadmill stress testing), pulmonary function testing, vascular laboratory testing, and others	RESULT EVENT ENTRY 15.01 Result ID 15.02 Result Date/Time 15.03 Result Type 15.04 Result Status 15.05 Result Value 15.06 Result Interpretation 15.07 Result Reference Range	2.2.2.15 RESULT	ORU - Unsolicited transmission of an observation message OBX – Observation/Result	NOTE: Units may be text data currently
Encounter	Encounter	A patient encounter represents interaction between a healthcare provider and a patient as with a face to face or otherwise billable visit for any form of diagnostic treatment and/or therapeutic event. Each encounter has an associated location within which it occurred. The encounter location is the	ENCOUNTER EVENT ENTRY 16.01 Encounter ID 16.02 Encounter Type 16.03 Encounter Free Text Type 16.04 Encounter Date/Time 16.05 Encounter Provider 16.06 Admission Source 16.07 Admission Type 16.09 Discharge Disposition	2.2.1.27; 2.2.2.16 ENCOUNTER	PV1 - Patient Visit PV2 - Patient Visit - Additional Information	NOTE: For CDA, Terminologies supporting CMS Measures related HITSP Data Element: ED Departure Date/Time (16.16, 16.20) ICU Admission

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		patient's locality at the time of measurement	16.10 Patient Class 16.11 In Facility Location 16.12 Arrival Date/Time 16.13 Reason for Visit 16.14 Admit Date/Time 16.16 Discharge Date/Time 16.17 Facility ID 16.18 Facility Name 16.19 Facility Address 16.20 In Facility Location Duration			Date/Time (16.04, 16.14, 16.15) ICU Admission or Transfer (16.12, 16.14, 16.15, 16.16, 16.20) ICU Discharge Date/Time (16.16) Reason for Admission (16.13) Visit Data (16.01, 16.02) NOTE: Need to identify "Facility" info associated with the "Date/Time" of arrival/departure. Policy to assure that the Date/Time populated is the time the patient PHYSICALLY arrived/departed the facility. "16.13": Reason for Visit shall be populated by the PROCEDURE intended "16.15": **SHALL** include ability to express decision to admit from ED 16.16: For hospital stays, encounter date/time high should be used to represent the discharge time. 00:00 = next day, 11:59 pm = previous 16.12 Arrival

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
						Date/Time -modeled with the understanding that this is the actual time that the patient arrives at the facility or ED -modeled as a component in an encounter with a SNOMED code "Time of arrival at hospital"16.20 "In facility duration (high) i.e. (ED Departure Time) In Facility Location – Policy needed to assure that the Date/Time populated is the time the patient PHYSICALLY departed the ED ICU Admission Date--- needs to capture that actual Date/Time the patient was physically admitted to the ICU 16.13 Reason for Visit Shall be populated by the procedure where elective surgery
Functional status:	Functional status	The capacity to engage in activities of daily living and social role activities	GAP	2.2.2.21 Functional Status	PV1-15 Ambulatory Status	Constrain vocabulary to SNOMED codes GAP for Functional status survey
Individual characteristic	Patient characteristics	Specific information about the patient, including demographics	Timestamp Patient Information Entry Person ID Person Address Person Phone/Email/URL	2.2.2.1 PERSONAL INFORMATION 2.2.2.2 LANGUAGE SPOKEN (2.01) 2.2.2.3 SUPPORT)	PID – Patient Identification	Terminologies supporting CMS Measures related HITSP Data Element: Person ID (1.02)

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
			Personal Information Person Name Gender Person Date of Birth Marital Status Religious Affiliation Race Ethnicity 2.01 Language SUPPORT 3.01 Date Contact 3.02 Contact Type 3.03 Contact Relationship 3.04 Contact Address 3.05 Contact Phone/Email/URL 3.06 Contact Name PAYMENT PROVIDER EVENT ENTRY*** 5.02 Health Insurance Type Member Information 5.07 Health Plan Coverage Dates 5.08 Member ID 5.09 Patient Relationship to Subscriber 5.14 Financial Responsibility Party Type PROBLEM ENTRY *** 7.06 Age (at Onset) 7.07 Cause of Death 7.08 Age (at Death) *** not all data elements from section listed	2.2.2.7 CONDITION 2.2.2.5 INSURANCE PROVIDER		Pseudonymized Data Linker (1.02) Sex (1.06) Patient HIC number; Patient's Medicare health insurance claim number (1.02) Postal code (1.03) Payment source (5.02, 5.14) NOTE: "1.11 Ethnicity": Need Joint Commission Hispanic Ethnicity All personal information subject to anonymization where required by policy (CMS requires name) GAP (Need Data and/or Modeling): Clinician Trial Enrollment Disposition of body Method to determine death Place of death Time of death NOTE: Method – e.g. cardiac death, brain death (SNOMED concepts for both)
Individual characteristic	Provider characteristics	Specific information about the clinician provider or the facility caring for the patient	PROVIDER (4.XX) 4.01 Date Range 4.02 Provider Role Coded 4.03 Provider Role Free Text 4.04 Provider Type 4.05 Provider Address 4.06 Provider Phone Email/URL 4.07 Provider Name 4.08 Provider's Organization Name	2.2.2.4 HEALTHCARE PROVIDER 2.2.2.7 CONDITION 2.2.1.3 PROBLEM LIST 2.2.2.8 MEDICATION 2.2.1.27; 2.2.2.16 ENCOUNTER	ORC-12 Ordering Provider (Orders) OBR-15 Ordering Provider (Results) PV1-6 Attending Doctor PV1-7 Referring Doctor PV1-8 Consulting	A facility may have many identifiers and cda:id = 1..* Terminologies supporting CMS Measures related HITSP Data Element: Clinician Declaring Death (7.05, 7.11)

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
			4.09 Provider's Patient ID PROBLEM ENTRY (7.XX)*** 7.05 Treating Provider 7.11 Treating Provider ID MEDICATION (8.XX)*** 8.31 Ordering Provider 8.35 Provider ENCOUNTER** 16.05 Encounter Provider 16.10 Patient Class 16.11 In Facility Location 16.17 Facility ID 16.18 Facility Name 16.19 Facility Address 16.20 In Facility Location Duration *** not all data elements from section listed		Doctor Using (Unique Provider Identifier) using CX ROL Role Segment PRA Practitioner Detail Segment	
Laboratory test	Laboratory test declined	A study in the clinical laboratory (traditionally Chemistry, Hematology, Microbiology, Serology, Urinalysis, Blood Bank) has been declined by the patient or patient proxy. Depending on the point in the clinical workflow desired by the measure, various options are provided - offered, declined, ordered, performed and resulted NOTE: Proposed to include in the definition the following –This may also include the scenario where the stated entity is ordered but is not completed because it was not scheduled, cancelled, not tolerated, rescinded, no-show, equipment /system failure due to "Reason(s)" listed in the Constraints	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site COMMENT 11.03 Tense	2.2.2.17 PROCEDURE 2.2.2.11Comment	GAP	For CDA, Constrain 11.03: HL7 ActMood = INT negation IND = True has Reason HL7 ActReason -- 3 categories: PATIENT REASON MEDICAL REASON SYSTEM REASON See OVERLAPs for expression of ActReason See GAPs for classification of ActReason into: PATIENT REASON MEDICAL REASON SYSTEM REASON
Laboratory test	Laboratory test offered	A study in the clinical laboratory (traditionally Chemistry, Hematology, Microbiology,	PROCEDURES 17.01 Procedure 17.02 Procedure Type	2.2.2.17 PROCEDURE 2.2.1.8 LIST OF	GAP NOTE: For HL7 messaging, Order	For CDA, Constrain 11.03: HL7 Act Mood = INT

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		Serology, Urinalysis, Blood Bank) has been offered to the patient or patient proxy. Depending on the point in the clinical workflow desired by the measure, various options are provided - offered, declined, ordered, performed and resulted	17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site COMMENT 11.03 Tense	SURGERIES (under development) 2.2.2.11Comment	management workflow – there was an order and status is cancelled – Order Status – Action item to work on Lab orders construct – relies on HL7 orders – controlled vocabulary terms	- where INT (intent) 10199
Laboratory Test:	Laboratory test order	A study in the clinical laboratory (traditionally Chemistry, Hematology, Microbiology, Serology, Urinalysis, Blood Bank) has been ordered. Depending on the point in the clinical workflow desired by the measure, various options are provided - offered, declined, ordered, performed and resulted	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site RESULT EVENT ENTRY 15.01 Result ID 15.02 Result Date/Time 15.03 Result Type 15.04 Result Status 15.05 Result Value 15.06 Result Interpretation 15.07 Result Reference Range COMMENT 11.03 Tense	2.2.2.17 PROCEDURE (2.2.1.8 LIST OF SURGERIES (under development) 2.2.2.15 RESULT 2.2.2.11 Comment	ORU - Unsolicited transmission of an observation message	For CDA, Constrain 11.03: HL7 Act Mood = RQO - where RQO (Request)
Laboratory test:	Laboratory test performed	A study in the clinical laboratory (traditionally Chemistry, Hematology, Microbiology, Serology, Urinalysis, Blood Bank) has been completed. Depending on the point in the clinical workflow desired by the measure, various options are provided - offered, declined, ordered, performed and resulted	RESULT EVENT ENTRY 15.01 Result ID 15.02 Result Date/Time 15.03 Result Type 15.04 Result Status 15.05 Result Value 15.06 Result Interpretation 15.07 Result Reference Range PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type	2.2.2.15 RESULT	ORU - Unsolicited transmission of an observation message	

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
			17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site			
Laboratory test	Laboratory test result	The result of a study in the clinical laboratory (traditionally Chemistry, Hematology, Microbiology, Serology, Urinalysis, Blood Bank). Depending on the point in the clinical workflow desired by the measure, various options are provided - offered, declined, ordered, performed and resulted	RESULT EVENT ENTRY 15.01 Result ID 15.02 Result Date/Time 15.03 Result Type 15.04 Result Status 15.05 Result Value 15.06 Result Interpretation 15.07 Result Reference Range PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site	2.2.2.15 RESULT	ORU - Unsolicited transmission of an observation message OBX - Observation	Use 15.02 for Report Date/Time
Medication	Medication, active	Medications currently taken by a patient	MEDICATION: ADMINISTRATION INFOEVENT ENTRY 8.01 Free Text Sig 8.02 Indicate Medication Stopped 8.03 Administration Timing 8.04 Frequency 8.05 Interval 8.06 Duration 8.07 Route 8.08 Dose 8.09 Site 8.10 Dose Restriction 8.11 Product Form 8.12 Delivery Method MEDICATION INFORMATION 8.13 Coded Product Name 8.14 Free Text Product Name 8.15 Free Text Product Name 8.16 Free Text Brand Name 8.17 Drug Manufacturer 8.18 Product Concentration	2.2.1.12 MEDICATIONS SECTION 2.2.2.8 MEDICATIONS 2.2.1.17; 2.2.2.13 IMMUNIZATION	RDS^O17 Pharmacy/Treatment Administration Message RDS^O13 Pharmacy Dispense Message	

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
			8.19 Type of Medication 8.20 Status of Medication 8.21 Indication 8.22 Patient Instructions 8.23 Reaction 8.24 Vehicle 8.25 Dose Indicator ORDER INFORMATION 8.26 Order Number 8.27 Fills 8.28 Quantity Ordered 8.29 Order Expiration Date/Time 8.30 Order Date/Time 8.31 Ordering Provider 8.32 Fulfillment Instructions 8.33 Fulfillment History 8.34 Prescription Number 8.35 Provider 8.36 Location 8.37 Dispense Date 8.38 Quantity Dispensed 8.39 Fill Number 8.40 Fill Status			
			IMMUNIZATION EVENT ENTRY 13.01 Refusal 13.02 Administered Date 13.03 Medication Series Number 13.04 Reaction 13.05 Performer MEDICATION INFORMATION 13.06 Coded Product Name 13.07 Free Text Product Name 13.08 Drug Manufacturer 13.09 Lot Number 13.10 Refusal Reason			
Medication	Medication administered	A record by the care provider that a medication actually was administered and whether or not this fact conforms to the order. Appropriate time stamps for all	MEDICATION ENTRY (8.01 – 8.40)**** IMMUNIZATION EVENT ENTRY (13.01 – 13.10)**** ****See the row of "medication, active"	2.2.2.8; 2.2.1.12 MEDICATIONS 2.2.1.15 MEDICATIONS ADMINISTERED	RDS^O17 Pharmacy/Treatment Administration Message	

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		medication administration are generated	for complete list of HITSP Data Element numbers stated	2.2.1.17; 2.2.2.13 IMMUNIZATION		
Medication	Medication adverse event	Medication Adverse Event: In the instance of a quality measure, a medication adverse event is an unexpected or dangerous reaction to a medication. Serious adverse events are those that are fatal, life-threatening, permanently/significantly disabling those that require or prolong hospitalization, those that lead to congenital anomaly or require intervention to prevent permanent impairment or damage. A time/date stamp is required as are notations indicating whether item is patient reported and/or provider verified	ADVERSE EVENT ENTRY 6.01 Adverse Event Date 6.02 Adverse Event Type Product Product Detail 6.03 Product Free-Text 6.04 Product Coded Reaction 6.05 Reaction Free-Text 6.06 Reaction Coded Severity 6.07 Severity Free-Text 6.08 Severity Coded MEDICATION ENTRY (8.01 – 8.40)**** IMMUNIZATION EVENT ENTRY (13.01 – 13.10)**** ****See the row of "medication, active" for complete list of HITSP Data Element numbers stated	2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS 2.2.2.6 ALLERGY/DRUG SENSITIVITY 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.15 MEDICATIONS ADMINISTERED 2.2.2.8; 2.2.1.12 MEDICATIONS 2.2.1.17; 2.2.2.13 IMMUNIZATION	IAM Adverse Reaction Information	Note: The context is specified (Vocabulary in HITSP/C80 Section 2.2.3.3.5 specifies code system name: SNOMED CT)
Medication	Medication allergy	Medication Allergy: A medication allergy is an immunologically mediated reaction that exhibits specificity and recurrence on re-exposure to the offending drug. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified	ADVERSE EVENT ENTRY 6.01 Adverse Event Date 6.02 Adverse Event Type Product Product Detail 6.03 Product Free-Text 6.04 Product Coded Reaction 6.05 Reaction Free-Text 6.06 Reaction Coded Severity 6.07 Severity Free-Text 6.08 Severity Coded MEDICATION ENTRY (8.01 – 8.40)**** IMMUNIZATION EVENT ENTRY (13.01 – 13.10)****	2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS 2.2.2.6 ALLERGY/DRUG SENSITIVITY 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.15 MEDICATIONS ADMINISTERED	AL1 Patient Allergy Segment	Note: The context is specified

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
			****See the row of "medication, adverse event" for complete list of HITSP Data Element numbers stated	2.2.2.8; 2.2.1.12 MEDICATIONS 2.1.2.12; 2.2.1.17; 2.2.2.13 IMMUNIZATION		
Medication	Medication declined	A medication has been declined by the patient or patient proxy	MEDICATION ENTRY (8.01 – 8.40)**** IMMUNIZATION EVENT ENTRY (13.01 – 13.10)**** ****See the row of "medication, active" for complete list of HITSP Data Element numbers stated COMMENT 11.03 Tense	2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.15 MEDICATIONS ADMINISTERED 2.2.1.12; 2.2.2.8 MEDICATION 2.2.1.17; 2.2.2.13 IMMUNIZATION 2.2.2.11 Comment	GAP	For CDA, Constrain 11.03: HL7 ActMood = INT negation IND = True has Reason HL7 ActReason -- 3 categories: PATIENT REASON MEDICAL REASON SYSTEM REASON See OVERLAPs for expression of ActReason See GAPs for classification of ActReason into: PATIENT REASON MEDICAL REASON SYSTEM REASON
Medication	Medication dispensed	A medication prescription is filled by a pharmacy the medication has been provided to the patient or patient proxy. In the ambulatory setting, medications are primarily taken directly by patients and not directly observed. Hence, dispensed is the closest health provider documentation of medication compliance. In settings where patients attest to taking medications in electronic format (perhaps a Personal Health Record) patient attestation of 'medication taken' may be available	MEDICATION ENTRY 8.37 - Dispense Date 8.38 - Quantity Dispensed 8.39 Fill number 8.40 Fill Status (8.01 – 8.40)**** IMMUNIZATION EVENT ENTRY (13.01 – 13.10)**** ****See the row of "medication, active for complete list of HITSP Data Element numbers stated	2.2.1.12 MEDICATIONS 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.12; 2.2.2.8 MEDICATION 2.2.1.17; 2.2.2.13 IMMUNIZATION	RDS^O13 Pharmacy Dispense Message	NOTE: Based upon the type of information that can be conveyed in the implementation, the computation for medication outpatient duration may differ
Medication	Medication	Medications taken by a patient in	MEDICATION ENTRY	2.2.1.13 ADMISSION	RDS^O17	NOTE: Expect that

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
	history	the past	(8.01 – 8.40)**** IMMUNIZATION EVENT ENTRY (13.01 – 13.10)**** ****See the row of "medication, active" for complete list of HITSP Data Element numbers stated	MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.12; 2.2.2.8 MEDICATIONS 2.2.1.17; 2.2.2.13 IMMUNIZATION	Pharmacy/Treatment Administration Message RDE Pharmacy/Treatment Refill Authorization Request Message	prescriptions at discharge are included in the discharge summary Used to compute: Anticoagulation Therapy Prescribed At Discharge

Medication	Medication intolerance	Medication Intolerance: Medication intolerance is a reaction in specific patients representing a low threshold to the normal pharmacological action of a drug. Side effects experienced do not represent adverse events or allergies. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified	ADVERSE EVENT ENTRY
			  6.01 Adverse Event Date
			  6.02 Adverse Event Type
			Product
			Product Detail
			  6.03 Product Free-Text
			  6.04 Product Coded
			Reaction
			  6.05 Reaction Free-Text
			  6.06 Reaction Coded
			Severity
			  6.07 Severity Free-Text
			  6.08 Severity Coded
			MEDICATION ENTRY (8.01 – 8.40)****
			IMMUNIZATION EVENT ENTRY (13.01 – 13.10)****
			****See the row of "medication, active" for complete list of HITSP Data Element numbers stated
				2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS 2.2.2.6 ALLERGY/DRUG SENSITIVITY 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.15 MEDICATIONS ADMINISTERED 2.2.2.8; 2.2.1.12 MEDICATIONS 2.2.1.17; 2.2.2.13 IMMUNIZATION	OBX - Observation	Adverse Event Type shall indicate '59037007' Drug intolerance

Medication	Medication offered	A specific medication has been offered to the patient or patient proxy	MEDICATION ENTRY (8.01 – 8.40)**** IMMUNIZATION EVENT ENTRY (13.01 – 13.10)**** ****See the row of "medication, active" for complete list of HITSP Data Element numbers stated COMMENT 11.03 Tense	2.2.1.12 MEDICATIONS 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION	GAP	For CDA, Constrain 11.03: HL7 Act Mood = INT - where INT (intent) 10199

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
				2.2.1.15 MEDICATIONS ADMINISTERED 2.2.1.12; 2.2.2.8 MEDICATION ; 2.2.1.17; 2.2.2.13 IMMUNIZATION 2.2.2.11 Comment		
Medication	Medication order	A request by a physician or appropriately licensed care provider to a pharmacy to provide medication to a patient. The request is in the form of prescriptions or other medication orders with detail adequate for correct filling and administration	MEDICATION ENTRY (8.01 – 8.40)**** IMMUNIZATION EVENT ENTRY (13.01 – 13.10)**** ****See the row of "medication, active" for complete list of HITSP Data Element numbers stated	2.2.1.12 MEDICATIONS 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.15 MEDICATIONS ADMINISTERED 2.2.1.12; 2.2.2.8 MEDICATION 2.2.1.17; 2.2.2.13 IMMUNIZATION	RDS^O13 Pharmacy Dispense Message RXO-1 Requested Give Code	NOTE: Prefer RxNORM, NDF-RT
Physical finding	Physical exam finding	A physical examination is the evaluation of the patient's body to determine its state of health. The techniques of inspection include palpation (feeling with the hands and/or fingers), percussion (tapping with the fingers), auscultation (listening), and smell. Measurements may include vital signs (blood pressure, pulse, respirations) as well as other clinical measures (such as expiratory flow rate, size of lesion, etc.)	14.01 Vital Sign Result ID 14.02 Vital Sign Result Date/Time 14.03 Vital Sign Result Type 14.04 Vital Sign Result Status 14.05 Vital Sign Result Value 14.06 Vital Sign Result Interpretation 14.07 Vital Sign Result Reference Range RESULT EVENT ENTRY 15.01 Result ID 15.02 Result Date/Time 15.03 Result Type 15.04 Result Status 15.05 Result Value 15.06 Result Interpretation 15.07 Result Reference Range	2.2.1.19; 2.2.2.14 VITAL SIGN 2.2.2.15 RESULT 2.2.2.7 CONDITION 2.2.1.18 PHYSICAL EXAMINATION SECTION (Reference to IHE Physical Examination section, HL7 History and Physical Note and HL7 Consultation Note)	ORU - Unsolicited transmission of an observation message OBX - Observation	Constrain Problem type code to "Finding and Functional Limitation" Physical exam-vitals was identified by HITSP to have multiple data elements needed to represent the concept, including: Blood Pressure – Diastolic Observation (2.1.2.13 VITAL SIGN) Blood Pressure – Systolic Observation (2.1.2.13 VITAL SIGN)

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
			PROBLEM ENTRY 7.01 Problem Date 7.02 Problem Type 7.03 Problem Name 7.04 Problem Code 7.05 Treating Provider 7.06 Age (at Onset) 7.07 Cause of Death 7.08 Age (at Death) 7.09 Time of Death 7.10 Diagnosis Priority 7.11 Treating Provider ID 7.12 Problem Status			Note: See OVERLAPs: "PHYSICAL EXAMINATION" Section constrain section template to LOINC or SNOMED CMHR pending work to review modeling and possibly additional attributes associated with "Risk" Proposed: to monitor ongoing clinical LOINC to specify risk category (NOTE: Range may be associated with clinical interpretation which may be SNOMED; has Scale e.g. a risk category containing specific value) Interim Recommendation: Clinical procedure use LOINC; whereas for the "result" of procedures use SNOMED. Additional HITSP data elements for PHYSICAL EXAMINATION pending C80/C154 work. GAP Need to identify "source" of physical exam finding (e.g. a device originated

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
						value, patient originated, clinician taken)
Preference	Patient preference	Healthcare treatment choices influenced by but not limited to language, religious, or cultural preferences selected by the patient and family	GAP	GAP	GAP	NOTE: Code Status: "history-care classification (CMO, DNR/I, pal care)*"Patient consent for use of information may be part of this (See SNOMED CT Procedure 133918004)385897008 – Care Regimes Management). GAP: NOTE: currently modeled using code status values **SHALL** be selected from a SNOMED values set with values descending from 365870005 "Finding of resuscitation status" NOTE: New SNOMED Codes are needed
Preference:	Provider preference	Healthcare treatment choices by the care provider based on knowledge of the patient's clinical status and findings. Synonymous with 'medical reason' for inclusion or exclusion of a patient in a measure population	GAP	GAP	GAP	Proposed examples: - Exclusions due to beliefs and training - Medical reasons for not doing a procedure
Procedure	Procedure adverse event	In the instance of a quality measure, a procedure adverse event is an unexpected or dangerous reaction to a procedure. Serious adverse events are those that are fatal, life-threatening, permanently/significantly disabling	ADVERSE EVENT ENTRY 6.01 Adverse Event Date 6.02 Adverse Event Type Product Product Detail 6.03 Product Free-Text 6.04 Product Coded	2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS 2.2.2.6 ALLERGY/DRUG SENSITIVITY	IAM Adverse Reaction Information	

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]

		those that require or prolong hospitalization, and those that require intervention to prevent permanent impairment or damage. A time/date stamp is required, as are notations indicating whether an item is patient-reported and/or provider-verified	Reaction
			  6.05 Reaction Free-Text
			  6.06 Reaction Coded
			Severity
			  6.07 Severity Free-Text
			  6.08 Severity Coded
			PROCEDURES
			17.01 Procedure
			17.02 Procedure Type
			17.03 Procedure Free Text Type
			17.04 Procedure Date/Time
			17.05 Procedure Provider
			17.06 Body Site
			MEDICATION ENTRY****
			  8.01-8.40****
			****See the row of "medication, active" for complete list of relevant HITSP Data Elements for medications
				2.2.2.17 PROCEDURE
				2.2.1.8 LIST OF SURGERIES (under development)
				2.2.1.12 MEDICATIONS
				2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION
				2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION
				2.2.1.15 MEDICATIONS ADMINISTERED
				2.2.1.12; 2.2.2.8 MEDICATION		

Procedure	Procedure declined	A procedure has been declined by the patient or patient proxy	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site MEDICATION ENTRY 8.01 – 8.40**** ****See the row of "medication, active for complete list of HITSP Data Element numbers stated COMMENT 11.03 Tense	2.2.2.17 PROCEDURE 2.2.1.8 LIST OF SURGERIES (under development) 2.2.1.12 MEDICATIONS 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.15 MEDICATIONS ADMINISTERED 2.2.1.12; 2.2.2.8 MEDICATION 2.2.2.11 Comment	GAP	For CDA, Constrain 11.03 where it is a procedure, where the procedure is the administration of a medication or substance, Constrain 8.13: **HL7 ActMood = INT negation IND = True has Reason HL7 ActReason** -- *3 categories:* PATIENT REASON MEDICAL REASON SYSTEM REASON See OVERLAPs for expression of ActReason See GAPs for classification of ActReason into:

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
						<u>PATIENT REASON</u> <u>MEDICAL REASON</u> <u>SYSTEM REASON</u>
Procedure	Procedure history	A procedure has been completed in the past and includes a time/date stamp. Chargeable vs. non-chargeable	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site MEDICATION ENTRY 8.01 – 8.40**** ****See the row of "medication, active" for complete list of HITSP Data Element numbers stated	2.2.2.17 PROCEDURE 2.2.1.8 LIST OF SURGERIES (under development) 2.2.1.12 MEDICATIONS 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.15 MEDICATIONS ADMINISTERED 2.2.1.12; 2.2.2.8 MEDICATION	PR1 - Procedure	NOTE: GAP (CMHR question) – How to handle procedures that are not billable (e.g. wound dressing changes)
Procedure	Procedure offered	A procedure is suggested or recommended to a patient	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site MEDICATION ENTRY**** 8.01-8.40**** ****See the row of "medication, active" for complete list of relevant HITSP Data Elements for medications COMMENT 11.03 Tense	2.2.2.17 PROCEDURE 2.2.1.8 LIST OF SURGERIES (under development) 2.2.1.12 MEDICATIONS 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.15 MEDICATIONS ADMINISTERED	GAP	For CDA, Constrain 11.03 where it is a procedure, where the procedure is the administration of a medication or substance, Constrain 8.13: HL7 Act Mood = INT - where INT (intent) 10199 NOTE: SNOMED – Non-compliant – refused services; Concept may be leveraged, but need to identify where this

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
				2.2.1.12; 2.2.2.8 MEDICATION 2.2.2.11 Comment		concept would be found
Procedure	Procedure order	A request by a physician or appropriately licensed care provider to an appropriate provider or facility to perform a procedure	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site MEDICATION ENTRY**** 8.01-8.40**** ****See the row of "medication, active" for complete list of relevant HITSP Data Elements for medications COMMENT 11.03 Tense	2.2.2.17 PROCEDURE 2.2.1.8 LIST OF SURGERIES (under development) 2.2.1.12 MEDICATIONS 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.15 MEDICATIONS ADMINISTERED 2.2.1.12; 2.2.2.8 MEDICATION 2.2.2.11 Comment	OMG order message type – OBR-4 Universal Service ID	HL7 Act Mood = RQO - where RQO (Request) NOTE: This is subject to harmonization of terms across HITSP. NOTE: Procedure in Request mood NOTE: Policy consideration: all discharge instructions given throughout the hospitalization to be indicated on discharge instructions. Education can occur at any time. Must be noted that: 1) The patient has received a copy, OR 2) The patient has refused a copy, OR 3) Copy not given because patient is impaired and caregiver not present
Procedure	Procedure performed	A procedure has been completed. Depending on the point in the clinical workflow desired by the measure, various options are provided - offered, declined, ordered, performed and resulted. Procedures also include patient care processes provided directly to a patient by a care provider to assist or direct a patient with activity or to	PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site MEDICATION ENTRY**** 8.01-8.40**** ****See the row of "medication, active"	2.2.2.17 PROCEDURE 2.2.1.8 LIST OF SURGERIES (under development) 2.2.1.12 MEDICATIONS 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION	PR1 Procedure	SHALL be constrained to SNOMED-CT for Quality NOTE: For future discussion - --- Need to determine whether "HEALTHCARE PROVIDER" needs to

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		apply single use or durable medical equipment. Examples include assisted ambulation, behavioral interventions (e.g., counseling provided), dressing changes, placement of antithrombotic devices, insertion or removal of intravascular access. Some of these procedures are not reimbursed	for complete list of relevant HITSP Data Elements for medications. PROVIDER (4.XX) 4.01 Date Range 4.02 Provider Role Coded 4.03 Provider Role Free Text 4.04 Provider Type 4.05 Provider Address 4.06 Provider Phone Email/URL 4.07 Provider Name 4.08 Provider's Organization Name 4.09 Provider's Patient ID	2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.15 MEDICATIONS ADMINISTERED 2.2.1.12; 2.2.2.8 MEDICATION 2.2.2.4 HEALTHCARE PROVIDER		be in all other "PROCEDURE" quality data types, in all "PROCEDURE" quality data types except "procedure, declined", or in none at all. The provider roles are provided as reference but require resolution of Overlap for full implementation See Overlap NOTE: Medications are included because they may be bound to the procedure or surgical event (e.g. Anesthesia – section in operative note of a surgical procedure, or a procedure note of procedures that do not enter the body cavity such as colonoscopy) NOTE: Anesthesia information can also be found in the Operative Note or Procedure Note
Procedure:	Procedure result	Procedure results are the findings identified as a result of the procedure. The result of a surgical procedure documents the actual procedure performed and the findings of the procedure. These findings are usually present in the	RESULT EVENT ENTRY 15.01 Result ID 15.02 Result Date/Time 15.03 Result Type 15.04 Result Status 15.05 Result Value 15.06 Result Interpretation	Operative note – specimens obtained, Finding from the test may happen with lab/path and can be reported in result Procedure note -	ORU - Unsolicited transmission of an observation message OBX - Observation	NOTE: Outcome: e.g. successfully removed/replace hip cancer – number of nodes removed Pathology result is lab

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		operative note (e.g., lymph node dissection with 15 lymph nodes obtained for biopsy). The procedure result is distinct from the pathology report which is a laboratory result datatype which could state 2 of 15 nodes positive for malignancy. It is also distinct from clinical outcome which could use various datatypes (e.g., patient characteristic 'alive' at 18 months post-operatively, or functional status datatype required pre-operatively and at 6, 12, and 18 months post-operatively)	15.07 Result Reference Range PROCEDURES 17.01 Procedure 17.02 Procedure Type 17.03 Procedure Free Text Type 17.04 Procedure Date/Time 17.05 Procedure Provider 17.06 Body Site MEDICATION ENTRY**** 8.01-8.40**** ****See the row of "medication, active" for complete list of relevant HITSP Data Elements for medications	GAP 2.1.2.14; 2.2.2.15 RESULT 2.1.2.16; 2.2.2.17 PROCEDURE 2.2.1.8 LIST OF SURGERIES (under development) 2.2.1.12 MEDICATIONS 2.2.1.13 ADMISSION MEDICATIONS HISTORY SECTION 2.2.1.14 HOSPITAL DISCHARGE MEDICATIONS SECTION 2.2.1.15 MEDICATIONS ADMINISTERED 2.2.1.12; 2.2.2.8 MEDICATION		result based on specimen
Risk category/ assessment	Risk category/ assessment	Risk category assessments include tools and calculators that suggest vulnerabilities for any given patient. Distinct from functional status, risk categorization uses findings, observations, results and sometimes judgments and patient generated information for use within clinical care algorithms, clinical decision support and severity analysis	N/A	N/A (see constraints section)	NA	NOTE: Logic applied to other data types could be used to create other risk category/assessment for use in measurement or clinical decision support. This data type does not require separate mapping in the electronic health record
Substance	Substance administered	A record by the care provider that a food or other substance actually was given to the patient and whether or not these facts conform to the order	GAP	GAP	GAP	NOTE: GAP for non-medication substance administration

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
Substance	Substance adverse event	In the instance of a quality measure, a substance adverse event is an unexpected or dangerous reaction to a substance (e.g., food, environmental agent). Serious adverse events are those that are fatal, life-threatening, permanently/significantly disabling those that require or prolong hospitalization, and those that lead to congenital anomaly or require intervention to prevent permanent impairment or damage. A date/time stamp is required as are notations indicating whether item is patient reported and/or provider verified	ADVERSE EVENT ENTRY 6.01 Adverse Event Date 6.02 Adverse Event Type Product Product Detail 6.03 Product Free-Text 6.04 Product Coded Reaction 6.05 Reaction Free-Text 6.06 Reaction Coded Severity 6.07 Severity Free-Text 6.08 Severity Coded	GAP 2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS 2.2.2.6 ALLERGY/DRUG SENSITIVITY	IAM Adverse Reaction Information	NOTE: GAP for non-medication and food adverse events
Substance	Substance allergy	A substance allergy is an immunologically mediated reaction that exhibits specificity and recurrence on re-exposure to the offending substance. A date/time stamp is required as are notations indicating whether the item is patient reported and/or provider verified	ADVERSE EVENT ENTRY 6.01 Adverse Event Date 6.02 Adverse Event Type Product Product Detail 6.03 Product Free-Text 6.04 Product Coded Reaction 6.05 Reaction Free-Text 6.06 Reaction Coded Severity 6.07 Severity Free-Text 6.08 Severity Coded	GAP 2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS 2.2.2.6 ALLERGY/DRUG SENSITIVITY	AL1 – Allergy Segment	NOTE: GAP for non-medication substance --- to discuss with CMHR
Substance	Substance declined	A substance has been declined by the patient or patient proxy	GAP	GAP	GAP	NOTE: GAP for non-medication substance --- to discuss with CMHR
Substance	Substance intolerance	Substance intolerance is a reaction in specific patients representing a low threshold to the normal effects of a substance. Side effects experienced do not represent adverse events or allergies. A date/time stamp is required as are	ADVERSE EVENT ENTRY 6.01 Adverse Event Date 6.02 Adverse Event Type Product Product Detail 6.03 Product Free-Text 6.04 Product Coded	2.2.1.2 ALLERGIES AND OTHER ADVERSE REACTIONS 2.1.2.6; 2.2.2.6 ALLERGY/DRUG SENSITIVITY	ORU - Unsolicited transmission of an observation message OBX - Observation	GAP: Vocabulary for non-medication substance -

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]

		notations indicating whether the item is patient reported and/or provider verified	Reaction
			  6.05 Reaction Free-Text
			  6.06 Reaction Coded
			Severity
			  6.07 Severity Free-Text
			  6.08 Severity Coded			

Substance	Substance ordered	A request by a physician or appropriately licensed care provider to provide food or other substance to a patient	GAP	GAP	GAP	GAP: Vocabulary for non-medication substance
Symptom:	Symptom active	A symptom is an indication that a person has a condition or disease. Some examples are headache, fever, fatigue, nausea, vomiting, and pain. [Source: UMLS]. Also, subjective of disease perceived by the patient. [Source: NCI]. As an example to differential symptom from finding, the patient's subjective symptom of fever is distinguished from the temperature (a finding) which has a source of temperature measuring device and recorder of the device (electronically) or an individual (healthcare provider, patient, etc)	PROBLEM ENTRY 7.01 Problem Date 7.02 Problem Type 7.03 Problem Name 7.04 Problem Code 7.05 Treating Provider 7.10 Diagnosis Priority 7.11 Treating Provider ID 7.12 Problem Xtatus	Symptoms may be reported in multiple locations within the CDA document depending upon the context. The following list indicates the possible CDA locations for reporting symptoms: 2.2.2.7 CONDITION 2.2.1.3 PROBLEM LIST (section points to Condition data elements) 2.2.1.4 HISTORY OF PAST ILLNESS 2.2.1.7 HISTORY OF PRESENT ILLNESS 2.2.1.5 CHIEF COMPLAINT 2.2.1.20 REVIEW OF SYSTEMS	PV2-3 Admit Reason	NOTE: Kaiser/VA may not be broad enough for the concepts NOTE: Symptoms are perceptions by the patient – this needs to be distinguished from problems sourced by the clinician; "symptoms-history"… insufficient to represent "symptoms-active" NOTE: Problem code shall be SNOMED using any SNOMED code needed to express the symptom Problem type **SHALL** be '418799008' – used to reflect Symptom 7.12 Problem Status **SHALL** be 'Active'
Symptom:	Symptom assessed	NCI – Subjective evidence of disease perceived by the patient. [Source NCI] As an example to differential symptom from finding, the patient's subjective symptom of fever is	PROBLEM ENTRY 7.01 Problem Date 7.02 Problem Type 7.03 Problem Name 7.04 Problem Code 7.05 Treating Provider	Symptoms may be reported in multiple locations within the CDA document depending upon the context. The	PRB Problem Detail Segment	History-symptoms – perhaps, but need to analyze further in modeling Problem type SHALL be '418799008' – used

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
		distinguished from the temperature (a finding) which has a source of temperature measuring device and recorder of the device (electronically) or an individual (healthcare provider, patient, etc)	7.11 Treating Provider ID 7.12 Problem status	following list indicates the possible CDA locations for reporting symptoms: 2.2.2.7 CONDITION 2.2.1.3 PROBLEM LIST (section points to Condition data elements) 2.2.1.4 HISTORY OF PAST ILLNESS 2.2.1.7 HISTORY OF PRESENT ILLNESS 2.2.1.5 CHIEF COMPLAINT 2.2.1.20 REVIEW OF SYSTEMS		to reflect Symptom
System characteristic	System characteristic	The structural configuration of an organization, e.g., nursing staff ratios, availability of durable medical equipment, health information technology structures (e.g., e-prescribing), and invasive procedure capabilities	GAP	GAP	GAP	NOTE: Could be modeled in observations/study findings. Could be documented in progress notes. Leveraging SNOMED Codes for : e.g. Medication Shortage, Bed Shortage, DME Shortage As expressed by ActReason for reflecting 'declined'
Transfer of care	Transfer from	The setting from which a patient is received (e.g., home, acute care hospital, skilled nursing, etc.) to the current location	ENCOUNTER EVENT ENTRY*** 16.04 Encounter Date/Time 16.06 Admission Source 16.09 Discharge Disposition 16.10 Patient Class 16.11 In Facility Location 16.17 Facility ID 16.18 Facility Name 16.19 Facility Address	2.2.1.27; 2.2.2.16 ENCOUNTER	PV1-44 – Admit Date/Time PV1-45 – Discharge Date/Time PV1-14 – Admission Source PV1-36 Discharge Disposition	NOTE: For discussion ---- concepts to represent should include: "location – current"

HITEP II Standard Element	HITEP II Quality Data Element	HITEP II Definition	HITSP Data Element	HITSP/C83 Mapping	HL7 Message	Additional Specifications[2]
			16.20 In Facility Location Duration *** not all data elements from section listed row for "Encounter" for complete listing of elements 16.01-16.20)		PV1-2 Patient Class PV1-3 Assigned Patient Location PV1-4 Admission Type	
Transfer of care	Transfer to	The setting from which a patient is released (e.g., home, acute care hospital, skilled nursing, etc.) to the current location	ENCOUNTER EVENT ENTRY*** 16.04 - Encounter Date/Time 16.06 Admission source 16.09 Discharge disposition 16.10 Patient Class 16.11 In Facility Location 16.17 Facility ID 16.18 Facility Name 16.19 Facility Address 16.20 In Facility Location Duration *** not all data elements from section listed (see row for "Encounter" for complete listing of elements 16.01-16.20)	2.2.1.27; 2.2.2.16 ENCOUNTER	PV1-44 – Admit Date/Time PV1-45 – Discharge Date/Time PV1-14 – Admission Source PV1-36 Discharge Disposition PV1-2 Patient Class PV1-3 Assigned Patient Location PV1-4 Admission Type	

2.3 STANDARDS

2.3.1 REGULATORY GUIDANCE

Table 2-46 Regulatory Guidance

Regulation	Description
No applicable regulatory guidance	

2.3.2 SELECTED STANDARDS

As this specification provides a library of the HITSP defined data elements that are used for mapping to data element from the HITSP selected standards, it does not specifically define any selected standards. The binding of the Selected Standards is done within the specific Component, Transaction or Transaction Package using the HITSP defined data elements.

Table 2-47 Selected Standards

Standard	Description
No applicable selected standards	

2.3.3 INFORMATIVE REFERENCE STANDARDS

Table 2-48 Informative Reference Standards

Standard Name	Reason for Use
No applicable informative references	

3.0 APPENDIX

The following sections include relevant materials referenced throughout this document.

- A listing of all HITSP Constraints defined within this document

3.1 HITSP CONSTRAINTS DEFINED IN THIS DOCUMENT

C154-[DE-1.03-1]   The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State

C154-[DE-1.03-2]   The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code

C154-[DE-1.03-3]   The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country

C154-[DE-1.06-1]   Gender **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.1. Administrative Gender

C154-[DE-1.08-1]   Marital Status **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.3.2 Marital Status CDA and HLV3

C154-[DE-1.09--1] Religious affiliation **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.8 Religious Affiliation

C154-[DE-1.10-1]   Race **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.7 Race

C154-[DE-1.11-1]   Ethnicity **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.2 Ethnicity

C154-[DE-1.15-1]]   The Age **SHALL** use UCUM Age Units

C154-[DE-1.16-1]   If born in the United States, the state part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State

C154-[DE-1.16-2]   If born in the United States the postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code

C154-[DE-1.16-3]   The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country

C154-[DE-2.01-1]   Language **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.9 Language

C154-[DE-2.01-2]   Sign language **SHALL** be treated as a separate language

C154-[DE-3.03-1]   The contact relationship **SHALL** have be coded as specified in HITSP/C80 Section 2.2.1.2.4 Personal Relationships

C154-[DE-3.04-1]   The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State

C154-[DE-3.04-2]   The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code

C154-[DE-3.04-3]   The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country

C154-[DE-4.02-1]   Provider role **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.8.1 Provider Role

C154-[DE-4.04-1]   Provider type **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.8.2 Provider Type

C154-[DE-4.05-1]   The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State

C154-[DE-4.05-2]   The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code

C154-[DE-4.05-3]   The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country

C154-[DE-5.02-1]   The Health Insurance Type **SHALL** be coded as specified in HITSP/C80 Section 2.2.2.1 Health Insurance Type

C154-[DE-5.04-1]   The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State

C154-[DE-5.042]   The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code

C154-[DE-5.04-3]   The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country

C154-[DE-5.09-1]   The Patient Relationship to Subscriber **SHALL** be coded as specified in HITSP/C80 Section 2.2.2.2 Subscriber Relationship

C154-[DE-5.10-1]   The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State

C154-[DE-5.10-2]   The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code

C154-[DE-5.10-3]   The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country

C154-[DE-5.09-1]   The Patient Relationship to Subscriber **SHALL** be coded as specified in HITSP/C80 Section 2.2.2.2 Subscriber Relationship

C154-[DE-5.10-1]   The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State

C154-[DE-5.10-2]   The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code

C154-[DE-5.10-3]   The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country

C154-[DE-5.16-1]   The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State

C154-[DE-5.16-2]   The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code

C154-[DE-5.16-3]   The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country

C154-[DE-5.21-1]   The state part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.1 State

C154-[DE-5.21-2]   The postal code part of an address in the United States **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code

C154-[DE-5.21-3]   The country part of an address **SHALL** be recorded using HITSP/C80 Section 2.2.1.1.3 Country

C154-[DE-6.02-1]   The vocabulary used for adverse event types **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.4.2 Allergy/Adverse Event Type

C154-[DE-6.04-1]   Food and non-medicinal allergies/Sensitivities **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.11 Ingredient Name

C154-[DE-6.04-2]   Allergies/Drug Sensitivity to a class of medication **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.9 Medication Drug Class

C154-[DE-6.04-3]   Allergies/Drug Sensitivity to a specific medication **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.7 Medication Brand Name or HITSP/C80 Section 2.2.3.3.8 Medication Clinical Drug Names

C154-[DE-6.06-1]   The reaction **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.4.1 Allergy/Adverse Event (Reaction)

C154-[DE-6.08-1]   The terminology used for severity of the adverse event **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.4.3 Allergy/Adverse Event Severity

C154-[DE-7.02-1]   The problem type **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.2 Problem Type

C154-[DE-7.04-1]   The problem **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.1 Problem

C154-[DE-7.12-1]   The problem **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.8 Problem Status

C154-[DE-8.07-1]   **SHOULD** be coded using value sets consistent with those specified in HITSP/C80 Section 2.2.3.3.4.1 Medication Route FDA

C154-[DE-8.08-1]   Units **MAY** be present when needed. If present it **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.6.6 Units of Measurement

C154-[DE-8.08-2]   When the coded product or brand name describes the strength or concentration of the medication, and the dosing is in administration units (e.g., 1 tablet, 2 capsules), units **SHOULD** contain the preferred name of the presentation units within braces { } using the units of presentation from the NCI Thesaurus

C154-[DE-8.09-1]   The Site **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.2.1 Body Site

C154-[DE-8.11-1]   **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.3 Medication Product Form

C154-[DE-8.13-1]   The coded product name **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.8 Medication Clinical Drug Names.

C154-[DE-8.13-2]   When only the class of the drug is known (e.g., Beta Blocker or Sulfa Drug), it **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.9 Medication Drug Class.

C154-[DE-8.13-3]   When only the medication ingredient name is know, the coded product name **MAY** be coded as specified in HITSP/C80 Section 2.2.3.3.11 Ingredient Name

C154-[DE-8.14-1]   The brand name **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.7 Medication Brand Name or 2.2.3.3.10 Medication Packaged Product.

C154-[DE-8.15-1]   This **SHOULD** be sufficient for a provider to identify a medication, and may include additional information such as strength, dose form, etc. If the name of the product is unknown, the type, purpose or other description may be supplied

C154-[DE-8.16-1]   This **MAY** include additional information such as strength, dose form, etc

C154-[DE-8.19-1]   The type of medication **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.3.5 Medication Type

C154-[DE-8.20-1]   The medication status **MAY** be recorded using the CCD Medication Status observation using the value set defined in the CCD

C154-[DE-8.21-1]   The indication **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.1 Problem

C154-[DE-8.24-1]   The Vehicle shall be coded as specified in HITSP/C80 Section 2.2.3.3.12 Medication Vehicle

C154-[DE-13.06-1] Immunizations **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.5.1 Vaccines Administered.

C154-[DE-13.07-1] This **SHOULD** be sufficient for a provider to identify a medication, and **MAY** include additional information such as strength, dose form, etc. If the name of the product is unknown, the type, purpose or other description **MAY** be supplied

C154-[DE-13.10-1] The reason for refusal **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.5.3 No Immunization Reason

C154--[DE-13.11-1]   The Administration notes **SHALL** be coded using the HITSP/C80 Section 2.2.3.5.4 Immunization Information Source

C154-[DE-14.03-1] Vital signs **SHOULD** be coded as specified in HITSP/C80 Section 2.2.3.6.4 Vital Sign Result Type

C154-[DE-15.03-1]   Result Type **SHOULD** be selected from LOINC (codeSystem 2.16.840.1.113883.6.1) or SNOMED CT (codeSystem 2.16.840.1.113883.6.96)

C154-[DE-15.03-2]   Result Type for laboratory results **SHOULD** be coded as specified in HITSP/C80 Section 2.2.3.6.1 Laboratory Observations

C154-[DE-15.02-1]   Result Interpretation **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.6.3 Result Normalcy Status

C154-[DE-16.02-1]   Encounter Type **SHOULD** be coded as specified in HITSP/C80 Section 2.2.3.9.3 Encounter Type

C154-[DE-16.06-1]   The Admission Source **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.9.1 Admission Source

C154-[DE-16.09-1]   The Discharge Disposition **SHALL** be coded as specified in
        HITSP/C80 Section 2.2.3.9.4 Discharge Disposition
C154-[DE-16.10-1]   Patient Class SHALL be coded as specified in HITSP/C80 Section
        2.2.3.9.5 Patient Class
C154-[DE-16.19-1]   The state part of an address in the United States **SHALL** be
        recorded using HITSP/C80 Section 2.2.1.1.1 State
C154-[DE-16.19-2]   The postal code part of an address in the United States **SHALL** be
        recorded using HITSP/C80 Section 2.2.1.1.2 Postal Code
C154-[DE-16.19-3]   The country part of an address **SHALL** be recorded using
        HITSP/C80 Section 2.2.1.1.3 Country
C154-[DE-18.04-1] The Family Member Relationship (to Patient) **SHALL** be coded as specified in
        HITSP/C80 Section 2.2.1.2.5 Family Relationship Type
C154-[DE-18.24-1] Gender **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.1
        Administrative Gender
C154-[DE-18.09-1] Race **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.7 Race
C154-[DE-18.10-1] Ethnicity **SHALL** be coded as specified in HITSP/C80 Section 2.2.1.2.2
        Ethnicity
C154-[DE-18.12-1] The problem type **SHALL** be coded as specified in HITSP/C80 Section
        2.2.3.1.2 Problem Type.
C154-[DE-18.12-2] The problem **SHALL** be coded as specified in HITSP/C80 Section 2.2.3.1.1
        Problem
C154-[DE-18.18-1] Components of a Genetic Laboratory Test **SHALL** be coded as specified in
        HITSP/C80 Section 2.2.3.11 Genetic Testing
C154-[DE-19.02-1] The Social History type **SHALL** be coded as specified in HITSP/C80 Section
        2.2.2.4 Social History Type

4.0 DOCUMENT UPDATES

The following sections provide the details of updates made to this document.

4.1 SEPTEMBER 30, 2009

No changes. This is the first published version of the document.

4.2 NOVEMBER 9, 2009

- Addition of Data Element 4.10 National Provider ID
- Addition of Data Element 7.12. Problem Status
- Addition of Section 11 – General Purpose Data Elements – 11.01 Free Text Comment 11.02
- Addition of Data Elements 18.23 Family Member Age, 18,26 Family Member Multiple Birth Order and 18.25 Family Member Problem Status
- Additions for Section 23 Clinical Research - Data Element 23.01 through 23.04
- Addition of Section 2.2. Data Mapping between other Data Systems,- HITEP II

4.3 JANUARY 18, 2010

- Updated Section 1.1 with HITSP/C154 Data Dictionary Purpose; Addition of TN904 Harmonization Framework and Exchange Architecture as reference document.
- Update Personal Information – Addition of Data Element 1.17 Identity Unknown Indicator, 1.18 Patient Account Number
- Updated Insurance Provider – Addition of Data Elements 5.25 Insurance Company Name, and 5.26 Advanced Beneficiary Notice
- Update Prescription & Non-Prescription – Rename of Data Elements 8.35 Provider to Dispensing Pharmacy and 8.36 Location to Dispensing Pharmacy Location (more descriptive) [per Data Architecture review]
- Addition of Sections 2.1.2.24 Order Data Elements 24.01 thru 24.15 and 2.1.2.25 Specimen 25.01 thru 25.12

The following changes have been made to address Public Comments.

- 7705, 7819, 7823, 7744, 7851, 7866, 7867, 7871, 7869, 8043, 8046, 8177, 8279, 8632

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

4.4 JANUARY 25, 2010

Upon approval by the HITSP Panel on January 25, 2010, this document is now Released for Implementation.

4.5 JANUARY 31, 2010

- Updated Section 2.1.2.16 Encounter 16.17 Facility ID definition.