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HL7 Version 3 Domain Analysis Model: Summary Behavioral Health Record, Release 1 – US Realm

July 2013

HL7 Informative Ballot

Sponsored by:
Community Based Collaborative Care Work Group

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Revision History

Rev	Date	By Whom	Changes	Notes
ballot D 1.0	November 28, 2011	Ioana Singureanu	Initial ballot draft for comment	
D 1.1	December 22nd, 2011	Ioana Singureanu	Added attributes to Assessment, revised Problem, added author to relevant classes, revised header	
D.1.3	January 23rd, 2012	Serafina Versaggi	Ballot reconciliation completed	
I1.0	March 25th, 2012	Serafina Versaggi	Informative Ballot - First Ballot	
I1.1	July 9, 2012	Serafina Versaggi	Ballot reconciliation completed. Added Glossary section with starter terms (to be fleshed out from existing glossaries)	
I2.0	March 6, 2013	Serafina Versaggi	Changes introduced in the May 2013 Ballot: 1) Updated Introduction section 2) Added Use Case Analysis - Informative Ballot 2 section containing additional use cases included in this analysis 3) Updated Behavioral Health Report - Information Analysis section, reorganized content into "domains" or logical groupings of information to facilitate subject matter expert review 4) Updated Value Set Analysis section to include suggested concepts for the creation of behavioral health-specific value sets	
I2.1	March 13, 2013	Serafina Versaggi	Added SNOMED-CT codes to each attribute for use in CDA R2 Implementation Guide	
I2.2	March 16, 2013	Serafina Versaggi	Updated Approach section. Updated sections: Use Case Analysis – Ballots 1 & 2 Updated headings for data element tables in template and removed figure #	
I2.3	June 6, 2013	Serafina Versaggi	Informative 2 ballot updated following May 2013 ballot reconciliation	

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1 BEHAVIORAL HEALTH INFORMATION EXCHANGE

1.1 Introduction

The Behavioral Health Domain Analysis project is evaluating the currency and comprehensiveness of Health Level 7 (HL7) Behavioral Health and Social Service standards against emergent requirements in the United States (U.S.) and internationally.

The principal goals of this project are:

(i.) To improve the health of at-risk populations by improving care coordination between specialty behavioral health, primary care and related human services providers, through systems interoperability,
(ii.) To improve provider performance accountability, and
(iii.) To support emerging Accountable Care Organizations (ACO).

The model described in this publication contains a harmonized analysis of data requirements for Behavioral Health services and outcomes. This analysis will be used to develop interoperability specifications and reference implementations to support continuity of care among behavioral health and human services agency providers as well as to satisfy outcomes reporting requirements to public agencies that pay for services and monitor the public's health.

The Summary Behavioral Health Record Domain Analysis Model (BH-DAM) targets initial use cases for sharing specialty Behavioral Health treatment records with:

- Primary care and other health and human service providers who support the same client,
- Public agencies who fund specialty Behavioral Health prevention and treatment services, and
- Public health agencies that monitor the health and quality of life for people who are at risk for behavioral health problems.

Current and future phases of this project increase the focus on at-risk youth. The project will continue to analyze additional use cases intended to enhance interoperability across a broad range of service settings where young people are identified to be at-risk and may receive services intended to reduce that risk. These use cases will be incorporated in future work and elaborated in the next release of this Domain Analysis Model.

1.1.1 Acknowledgements

This ballot was developed through the support of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Arizona Department of Health Services, the Texas Department of State Health Services, with modeling support provided by Eversolve, LLC.

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1.1.3 References

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http://www.hl7.org/permalink/?VocabTables.

This document references the following national standards and published articles:

- Health Information Technology Standards Panel (HITSP) Consultations and Transfers of Care Interoperability Specification 9 (IS-09) Use Case that has been released for implementation.
- Transitions of Care Use Case from the Office of National Coordinator (ONC) Standards and Interoperability (S&I).
- HITSP C-32 Summary Documents Using HL7 Continuity of Care Document (CCD) Component

specifications

- HL7 Electronic Health Record System – Functional Specifications (Normative Edition)
- HL7 Electronic Health Record System – Behavioral Health Profile
- Sowers, W. E. & Rowland, B. (2004). American Association of Community Psychiatry Principles for Managing Transitions in Behavioral Health Services. Psychiatric. Services. 55(11), 1271-1275

1.1.4 Approach

Figure 1 illustrates our approach to developing a standards-based specification for the interoperable exchange of Behavioral Health information.

The process involves subject matter experts (SME), modeling facilitators and terminology specialists working together to ensure that each element of the standard specification is grounded on concrete stakeholder requirements. Following each session, requirements are documented as a Domain Analysis Model (DAM) using UML modeling tools and the DAM draft content is reviewed by stakeholders and updated by the modeling facilitators in an iterative process over successive meetings.

By following this methodology, we can generate technical specifications that are directly traceable to the stakeholder business requirements. This process defines and documents the requirements to the extent that they can be used to develop technical designs and implementation guides.

Reference implementations (pilots) demonstrate the validity of technical designs. Feedback from reference implementations are used by stakeholders to make improvements to the domain analysis model and downstream specifications through this iterative process.

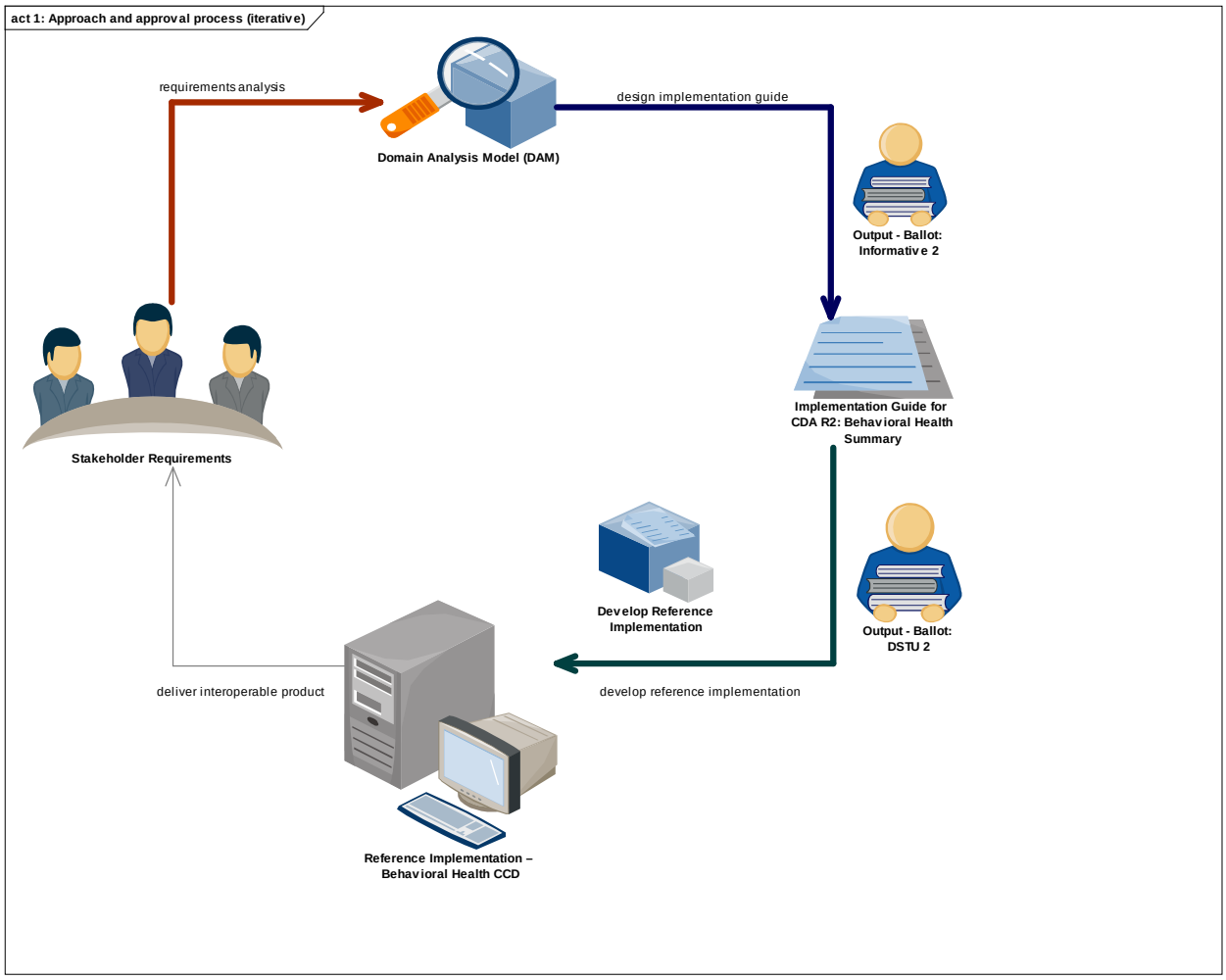

Figure 1: Approach and approval process (iterative)

1.1.4.1 Perform Requirements Analysis

1.1.4.1.1 Stakeholder Requirements

The starting point for analysis is gathering the real-life stakeholder requirements from various Behavioral Health providers, programs and agencies. The stakeholder group represents the subject matter experts for the area (domain) under analysis. The requirements are analyzed and result in the draft Domain Analysis Model (DAM). The DAM identifies:

- Use cases to specify the requirements,
- Life Cycle of a Behavioral Health Report including the business triggers for its exchange across agencies and providers, and
- Core information intended to be exchanged in a Behavioral Health report (data elements, data formats – string, coded, numeric, etc., code systems and suggested values)

The focus of this iteration of the DAM is to validate the content that was described in the original information analysis (Informative ballot 1) and to extend the model to include the expanded scope described in the Informative Ballot 2 Use Case Analysis section.

1.1.4.2 Ballot Domain Analysis Model (DAM)

1.1.4.2.1 Domain Analysis Model (DAM)

A Domain Analysis Model (DAM) is an abstract representation of a subject area of interest designed to provide a generic representation of a class of system or capability and to suggest a set of approaches to implementation.

A Domain Analysis Model is not concerned with the way in which the content will be implemented (e.g., represented in a CCD or other CDA document), but can serve as the basis for developing implementation guides that are traceable to stakeholder requirements. Use cases, interaction diagrams and other artifacts contained in domain analysis models also ensure that testing scenarios can be appropriately created for pilot and reference implementations.

A DAM produces a set of artifacts that clearly describe the healthcare requirements in terms familiar to the people who work in that business area. While DAMs are useful in walking subject matter experts (SME) through the analysis process, these models are also used as the basis for downstream specification design(s). The downstream designs may be functional models, service specifications, CDA Implementation Guides, message definitions, etc., depending on the type of standard targeted by the project. The standard specification may be directly based on reference information models and on the contents (information and operations) specified in the DAM or derived from the DAM through mappings and/or transformations.

While HL7 has pre-defined a set of states and transitions, the targeted business area may require different levels of granularity. These states and transitions will eventually be mapped or related to HL7 reference states and transitions for each type of Reference Information Model (RIM) class (e.g. Act, Managed Participation, Role, and Entity), thereby conforming to HL7 V3 Core principles.

The Domain Analysis Model for Summary Behavioral Health records described in this ballot is the result of analyzing stakeholder requirements regarding the exchange of Behavioral Health summary documents. These requirements will be used as the basis for developing CDA R2 Implementation Guides (IG) to support the exchange of Behavioral Health client data for a variety of use cases.

To accurately describe the intent for the DAM's guidance as it continues to be developed, it was renamed to "HL7 Version 3 Domain Analysis Model: Summary Behavioral Health Record" from it's original name "HL7 Version 3 Domain Analysis Model: Behavioral Health Assessment, Release 1" in the Informative 1 ballot.

The next generation of health care information systems is expected to automatically enforce all the requirements for health care interoperability. Aspects of the business use cases included in this analysis were gleaned from the HL7 EHR-S Functional Model Release 1- Infrastructure Functions. Analysis of the Behavioral Health stakeholder use cases included in this iteration of the Domain Analysis Model revealed the conceptual information structures and system interactions required to support the interoperability needs of Behavioral Health Providers and Programs. As the project continues to analyze new requirements for behavioral health information exchange between different service providers, additional use cases will be documented and elaborated upon in successive iterations of the DAM.

NOTE: The applicability of this DAM is limited to the use cases identified in the Behavioral Health Report Use Cases section and to the core data elements specified in the Behavioral Health Report Information Analysis section of this publication.

This DAM was developed following the HL7 Development Framework (HDF) process.

For further information about the HDF development process, see the HDF version 1.5 found at http://gforge.hl7.org/gf/download/frsrelease/608/6672/HDF_1.5.doc

1.1.4.2.2 Output - Ballot: Informative 2

The BH-DAM is balloted as an Informative standard and is published on the HL7 Ballot site under the Domain Analysis topic. This is the second iteration of the Informative BH-DAM.

1.1.4.3 Design Implementation Guide for CDA R2: Behavioral Health Summary Documents

1.1.4.3.1 Implementation Guide for CDA R2: Behavioral Health Summary

The DAM specifies the core content of a Behavioral Health Summary Record that may be exchanged using standards specified for certified EHR Systems. The BH-DAM is used as the basis for designing Implementation Guides for exchanging Behavioral Health Summary Record/Reports.

Based on updates to this Domain Analysis Model, the HL7 Implementation Guide for CDA R2: Behavioral Health Summary Document will be designed and balloted as a DSTU with the intent to become a normative standard following trial implementations.

That Implementation Guide (IG) will provide detailed guidance to implementers on how to create and consume the contents of these documents using the Clinical Document Architecture Release 2 (CDA R2).

We will refer to the templates defined in the HL7 Implementation Guide for CDA Release 2, Consolidated CDA Templates July 2012 ballot to ensure we re-use normative CDA templates where appropriate as they are referenced in the certification criteria for EHR-S (45 CFR Part 170 Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology) and the NPRM for Stage 2 Meaningful Use and CMS' Electronic Health Record Incentive Program.

During the design of the Implementation Guide, we plan to engage the HL7 Structured Documents Work Group for guidance on mapping Behavioral Health DAM content – the classes and attributes – to the appropriate CDA templates and elements.

1.1.4.3.2 Output - Ballot: DSTU 2

The HL7 Implementation Guide for CDA R2: Behavioral Health Summary Document is an additional balloted artifact (Draft Standard for Trial Use (DSTU)) intended to validate how the content identified in this Domain Analysis Model Informative standard is mapped to constructs specified by the Clinical Document Architecture Release 2 (CDA R2) and to any reusable templates produced by the Implementation Guide for CDA Release 2.0 Consolidated CDA Templates.

1.1.4.4 Develop Reference Implementation

1.1.4.4.1 Reference Implementation – Behavioral Health CCD

The final deliverable serves as a reference implementation (RI) to demonstrate how a standards-based Behavioral Health Summary document can support interoperable exchange of information related to Behavioral Health clients in treatment.

The RI will show how the BH Summary record can be instantiated and parsed by the sending and receiving systems. The development approach helped to ensure that the Reference Implementation is directly traceable to the stakeholders' business requirements.

1.1.4.4.2 Develop Reference Implementation

Once the Implementation Guide is complete, implementers can stand up a pilot implementation.

1.2 Behavioral Health Report - Use Cases

The scope for this domain analysis model has been documented in the form of use cases describing the purpose for the exchange of Behavioral Health Summary records/reports.

As this project continues to analyze interoperability requirements, new use cases will be added and existing use cases may be updated and elaborated as necessary to accommodate evolving requirements, policies and standards (e.g., updates to code systems and value sets, new domains, elements, and privacy protection metadata).

The Use Case section is organized to reflect the scope for each iteration of this Domain Analysis Model.

During the development of the Informative 2 ballot, our analysis expanded the scope of two primary Informative 1 ballot use cases (Report Behavioral Health Summary for Outcomes and Transitions of Care) and included new requirements to enable domains other than direct patient care (e.g., Criminal Justice, Homelessness, and other social service agencies and safety net organizations) to semantically interoperate with behavioral health providers when they are engaged with or providing services to behavioral health clients.

The new use cases are a work-in-progress and have not yet been as fully documented as the Informative Ballot 1 use cases. Future work on this project will refine the Informative Ballot 2 use cases to reflect additional analysis related to areas that were not yet fully defined in Informative Ballot 2. Any new use cases uncovered during that next phase of analysis will be included in the third iteration of this Domain Analysis Model.

1.2.1 Use Case Analysis - Informative Ballot 1

Figure 2 depicts the use cases that were included in the first Informative ballot (May 2012).

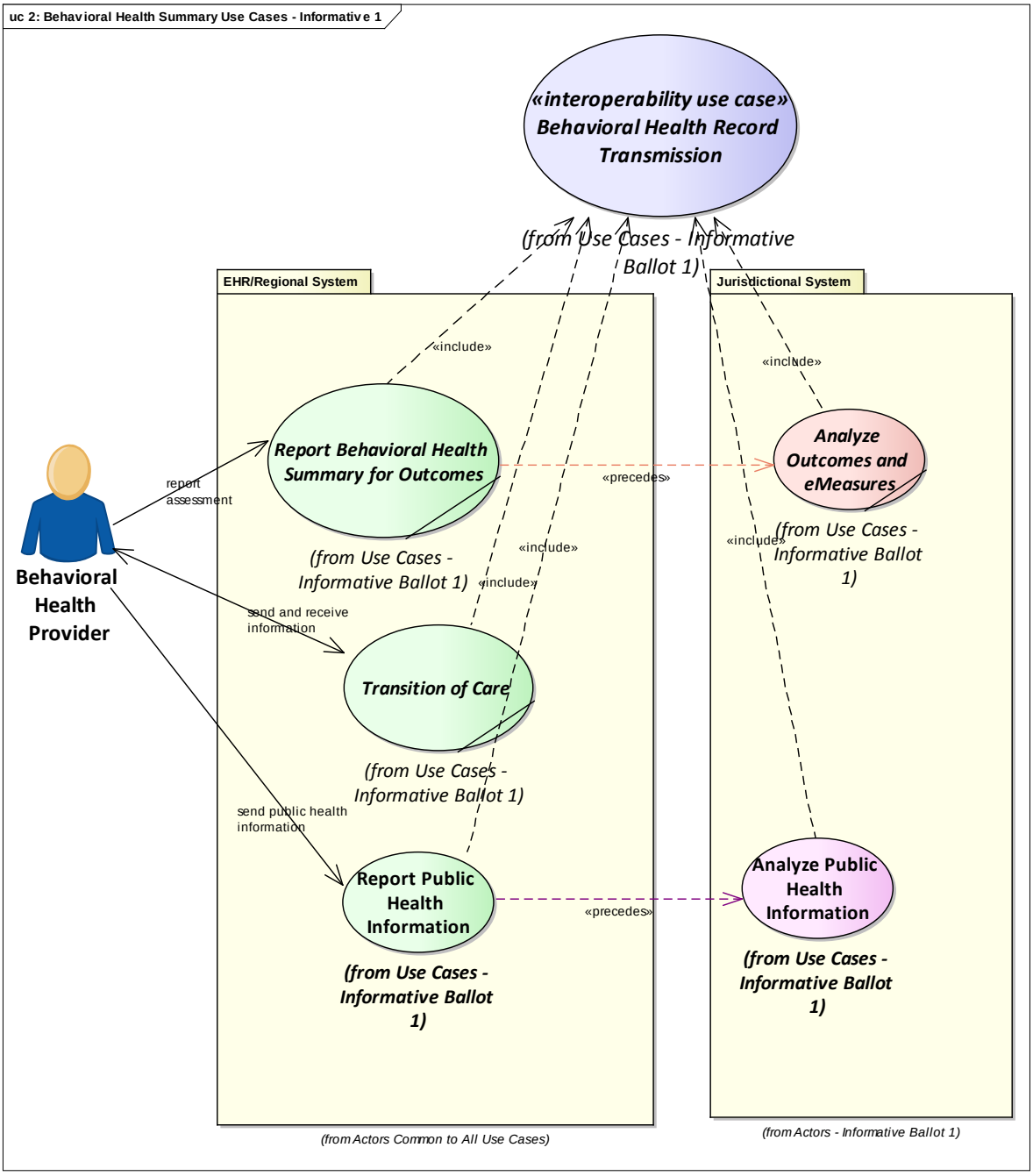

Figure 2: Behavioral Health Summary Use Cases - Informative 1

1.2.1.1 Use Cases - Informative Ballot 1

The following section describes the actors, systems and behaviors that are the focus of the use cases in Informative 1 ballot.

These use cases contain the basic requirements for EHR systems that are certified for Meaningful Use Stage 2, and that target patients with behavior health problems. Use cases focus on the clinical, functional status and outcome information of Behavioral Health clients that need to be exchanged between providers during a transfer of care or periodic assessment of problems during treatment service. The use cases assume that information is stored and shared electronically, and that data are time/date stamped using health information systems such as electronic health record systems (EHR-S) and other point-of-service systems used for the delivery of behavioral health prevention and treatment.

Some of the data elements and value sets supporting these use cases may have been updated since the first Informative ballot.

1.2.1.1.1 Analyze Public Health Information

The state/jurisdictional system implements this use case. It supports the automated processing of Public Health reports based on assessment or other longitudinal outcome data.

1.2.1.1.2 Report Public Health Information

The Report Public Health Information use case focuses on complete and timely measures of the incidence and prevalence of behavioral health and related social and economic problems, for target populations. The purpose is to quantify the scope and depth of these problems as they drive needs for health and human services, and as they indicate the success or failure of delivery of these services.

1.2.1.1.3 Behavioral Health Record Transmission

This technical use case supports the needs of stakeholders to report Behavioral Health outcomes. The trigger events are described in the Behavioral Health Report - Life Cycle section in Annex A.

This use case requires a Behavioral Health Continuity of Care Record - as described in the Behavioral Health Report - Information Analysis section of this document and supports the business use cases detailed below.

The information exchange requirements in this use case are derived from the Meaningful Use requirements. Also included in this exchange are requirements for the submission of bills to public insurance programs such as Medicaid.

1.2.1.1.4 Report Behavioral Health Summary for Outcomes

The Report Behavioral Health Summary for Outcomes use case focuses on Provider to Provider sharing of information related to a Behavioral Health client in support of a consultation. This includes referrals where the consulted physician takes charge of the client.

Specifically, this document addresses the required information transfers required during transfers between Tribal/Regional Behavioral Health Authorities in various US states.

In state Behavioral Health Services networks, activities may be coordinated at the county, regional or state level. In each case, the area authority, responsible for managing and facilitating the provision of care, has the authority and responsibility for coordinating care (based on eligibility determinations, except for out-of-area services - see Transitions of Care use case). The area authority is also responsible for ensuring that all pre-conditions to this use case are met before the scenario is executed.

Pre-Conditions:

- Detailed demographics, clinical, functional status and outcomes information is stored and available for electronic query and exchange between the primary actors. This is accomplished using standards-based EHR systems that are certified for Meaningful Use
- A Master Patient Index exists that uniquely identifies each client within the exchange community
- A Provider Directory exists that uniquely identifies each provider within the exchange community
- Each healthcare setting (hospital, clinic, nursing home, rehabilitation center etc.) has a unique identifier common to the exchange community
- Privacy and confidentiality issues have been addressed and necessary privacy consents are available for use. This includes availability of privacy and confidentiality codes in a standardized format
- Secure, standard connectivity exists between the primary actors (e.g., web, ftp, secure email (DIRECT)/NwHIN)
- User identity and access management processes and procedures are in place and in use in all electronic systems (employing user authentication and role-based access control)

Post Conditions:

- Physicians are able to access client records and receive complete, up-to-date, accurate demographics, clinical, functional status and outcomes information for clients, in a secure, standards-based format
- The information contains the client consent or other legal

authorization (patient care) codes
- The information has been filtered according to standardized confidentiality codes
- The information has been successfully transmitted to the appropriate State Agency for Substance Abuse or State Mental Health Authority.

Trigger Events:

- A primary care or admitting physician requests consultation with a specialist
- A client is transferred from one healthcare institution to another, or to a different physician
- A client is transferred from one managed care network to another (Cross-Regional Transfer)

Steps:

- This use case is initiated by the primary care or admitting physician during patient evaluation and care. The requesting (referring) physician initiates a consult request
- The consulting physician reviews the request and determines ability to accept the client in coordination with area authority
- The Consulting physician may request additional information from referring physician
- The Consulting physician evaluates/manages client and completes the consultation
- The referring physician, the client and the area authority each receive a copy of the report

1.2.1.1.5 Transition of Care

The Transitions of Care use case focuses on coordination of care during client transfers between one level or one type of care to another, and between different providers and facilities. It also includes information sharing among providers who serve the same person over time.

A transfer of care occurs when a client is discharged and transferred from one health care setting to another, such as between a hospital or clinic, skilled nursing or rehabilitation facility, or to home with or without home health care services. Clients participate in this electronic exchange of information as recipients of information exchange and may also designate authorized recipients of their health care information.

Coordination of care may involve primary medical care providers as well as other human services that safety net clients may need. It may generate more or less comprehensive longitudinal records that track an individual's service costs and behavioral problems over time. Such longitudinal tracking

enables services integration within health homes; and supports cost effectiveness assessment of service providers, modalities, and systems.

Pre-Conditions:

- Detailed demographics, clinical, functional status and outcomes information are stored and available for electronic query and exchange between the primary actors. This is accomplished using standards-based EHR systems that are certified for Meaningful Use.
- A Master Patient Index exists that uniquely identifies each client within the exchange community
- A Provider Directory exists that uniquely identifies each provider within the exchange community
- Each healthcare setting (hospital, clinic, nursing home, rehabilitation center etc.) has a unique identifier common to the exchange community
- Privacy and confidentiality issues have been addressed and necessary privacy consents are available for use. This includes availability of privacy and confidentiality codes in a standardized format
- Secure, standard connectivity exists between the primary actors (e.g., web, ftp, secure email (Direct)/NWHIN)
- User identity and access management processes and procedures are in place and in use in all electronic systems (employing user authentication and role-based access control)

Post Conditions:

The area authority initiates an inter area authority transfer on behalf of the provider. The transfer contains the following information:

- Client Name, Client ID, Address, Telephone number
- Home area authority ID, Date Sent, Primary Contact Name, Telephone
- Behavioral Health Provider
- Receiving area authority ID, Primary Contact Name, Telephone
- Documents enclosed (including complete behavioral health record if available)
- Number of days of service in an Institution of Mental Disorder in a contract year (for Title XIX persons between ages 21-64 only)
- Number of hours of respite service received for the contract year

Trigger Events:

- This use case is initiated by the service provider due to a change in the clinical or functional status of a client, or as part of a temporary or permanent relocation of a client
- Cross-Regional System transfers are completed within 30 days of referral

- During out-of-area service, the Home Regional System must be notified within 24 hours

Steps:

- The receiving area authority informs the home area authority within 7 days of any incomplete information received or proceeds with making arrangements for the transfer
- Within 14 days of receipt of the referral for inter area authority transfer, the receiving area authority schedules meetings with the home area authority, behavioral health provider and other responsible parties to establish a transition plan as per the inter area authority transfer policies.

1.2.1.1.6 Analyze Outcomes and eMeasures

The state/jurisdictional system implements this use case. It supports the automatic processing of Behavioral Health reports and assessments. The computation of quality and behavioral health outcomes relies on the information reported by the Behavioral Health Providers.

1.2.1.2 Actors - Informative Ballot 1

In addition to Actors Common to All Use Cases, the following actor was included in the first Informative ballot.

1.2.1.2.1 Jurisdictional System

This type of system represents a jurisdictional system that receives and analyzes summary reports and assessments sent by EHR or Regional System on behalf of providers. This type of system may be operated by a State Agency for Substance Abuse or State Mental Health Authority.

1.2.2 Use Case Analysis - Informative Ballot 2

Figure 3 provides a high-level overview of the actors, systems and behaviors that are the focus of the second Informative ballot (May 2013). This ballot introduces a new use case (Bill for Services) and expands on two of the original use cases (Transitions of Care and Report Behavioral Health Summary for Outcomes) in Coordinate Community-Based Care and Services Research and Report Provider Performance respectively. The use case documentation is limited to a brief narrative to illustrate the high-level requirements and will be enhanced to include steps, pre & post-conditions and trigger events in a subsequent phase of the project.

These new use cases are intended to demonstrate semantic interoperability between agencies that generally are silos of information. By demonstrating standards-based specifications for electronic exchange and by employing commonly shared data elements and value sets, information could be shared

across the health care systems and various social service agencies that hold information about behavioral health clients so that it can be used in a timely and secure manner, thereby improving care coordination and outcomes and reducing costs.

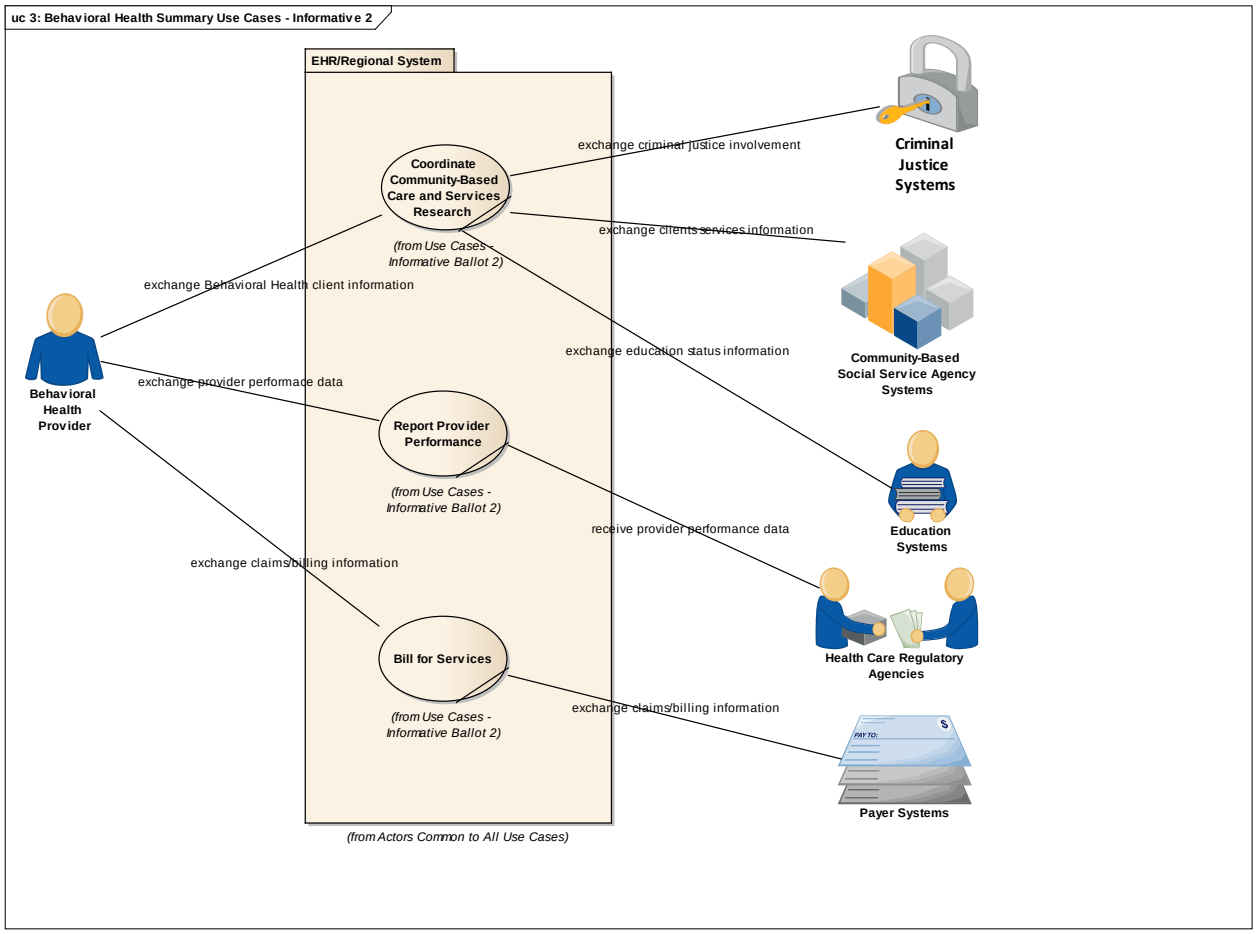

Figure 3: Behavioral Health Summary Use Cases - Informative 2

1.2.2.1 Use Cases - Informative Ballot 2

This section describes the actors, systems and behaviors that are involved in the Informative 2 ballot use cases.

Time constraints and resources prevented the project from analyzing these use cases at the same level of detail as for the Informative 1 ballot. As the project evolves, this section will be elaborated in a subsequent phase of the project.

1.2.2.1.1 Bill for Services

The Bill for Services use case focuses on services data that payers need to justify spending and to expose waste, fraud, and abuse. In addition to resource use and pricing, payment decisions may depend on documentation of evidence-based services, service outcomes, beneficiary satisfaction, and

the efficiency of bill administration based on reuse of data from point-of-service records. Payment decisions may also depend on the timely integration of a range of general and specialty services into programs that match individual needs.

1.2.2.1.2 Report Provider Performance

The Report Provider Performance use case focuses on how each provider and each ACO is offering and delivering specialty prevention and treatment services to target populations (access and utilization).

Data are required to show evidence of access to care, service needs, services delivered, costs, and service outcomes. Data should also reveal how different types of services are integrated over time to address evolving beneficiary needs, in most cost effective ways.

This use case is automatically performed by the EHR-System based on data entered into the EHR-System used to compute the measures. The measures to be computed are specified by Health Care Regulatory Agencies.

1.2.2.1.3 Coordinate Community-Based Care and Services Research

The Exchange Services and Community Health Research use case focuses on the accuracy, reliability, and other validation criteria that may apply to beneficiary service records. Data should support cross-sectional and longitudinal analysis that may reveal ways that prevention and treatment services can improve over time. Data should also support cross checking of self-reported information (by beneficiaries and service providers) among different health and human services providers and agencies.

1.2.2.2 Actors - Informative Ballot 2

These are the actors participating in the new use cases included in the second Informative ballot (May 2013).

1.2.2.2.1 Health Care Regulatory Agencies

This actor represents 'health care regulatory agencies' that monitor health care practitioners and facilities, provide information about industry changes, promote safety and ensure legal compliance and quality services.

Federal, state and local regulatory agencies often establish rules and regulations for the health care industry, and their oversight is mandatory. Some agencies, such as those for accreditation, require voluntary participation but are important because they provide rankings or certification of quality.

Examples of Health Care Regulatory Agency types include federal and state agencies such as the California state Department of Insurance and Department of Managed Health Care, The Joint Commission, Agency for Healthcare Research and Quality (AHRQ), etc.

1.2.2.2.2 Payer Systems

This actor represents the payers of health care services, including state, federal and private payers.

1.2.2.2.3 Social Service Agency Systems

These actors represent the social service agency systems that will participate in the exchange of information related to behavioral health clients in an effort to improve coordination of care between these agencies and services. This actor includes community-based agencies that may also involve transfers of care.

1.2.2.2.3.1 Community-Based Social Service Agency Systems

This is a newly defined actor in these use cases and may include community health centers as well as housing or other support services.

1.2.2.2.3.2 Criminal Justice Systems

This actor represents criminal justice system applications which may participate in sending and receiving information related to behavioral health clients who interact with the criminal justice system for one reason or another. At-risk youth are a particular focus for this area of exchange.

An inmate management system (IMS), also commonly called a jail management system (JMS) or an inmate information system (IIS), is software designed to support a jail's record-keeping, administrative, and supervisory needs.

The medical capabilities of IMS systems are generally restricted to patient visit scheduling, the recording of inmate vitals, physician orders pertaining to prosthetics and bunking placement dependent upon medical need, and medication disbursement by correctional staff.

1.2.2.2.3.3 Education Systems

This actor represents the Educational system that may exchange information relevant to youth attendance, health and psychosocial issues with behavioral health and primary care providers and social service agencies.

1.2.3 Actors Common to All Use Cases

The follow actors are common to all use cases included in this Domain Analysis Mode (Informative 1 & 2).

1.2.3.1 Behavioral Health Provider

This actor represents the Behavioral Health services provider/clinician who is exchanging summary information for a behavioral health client. This actor may be performed by persons in a number of roles including Primary Care Physicians (PCP), Nurse Practitioners, psychiatrists, other specialty providers, nursing homes, hospitals, rehabilitation facilities, clinics, health homes, or any type of community-based service agency provider serving behavioral health clients.

1.2.3.2 EHR/Regional System

This actor is the EHR or Regional System that allows providers to communicate information about the care of behavioral health clients to other providers or state/jurisdictional authorities.

1.3 Behavioral Health Summary - Information Analysis

Figure 4 on the following page depicts the entire Behavioral Health Summary Information Analysis, including all domains (classes) and data elements (attributes). The diagram is broken down into smaller sections in figures 5 through 8 for better readability.

The information model reflects the feedback received during iterative subject matter expert (SME) review sessions that focused on the original core content specified in the first Informative BH-DAM. From those sessions, new data element requirements were documented to support the additional use cases introduced in this phase of the project.

Legend: The number of times an element may occur is identified next to each data element. Repetitions are referred to as cardinality, depicted by the following representations:

[0..1] - optional, may occur once
[0..*] - optional, may occur ad infinitum
[1..*] - required, may occur ad infinitum

If repetitions are not specified, the element is required and can only occur once. There is no representation for required, only once.

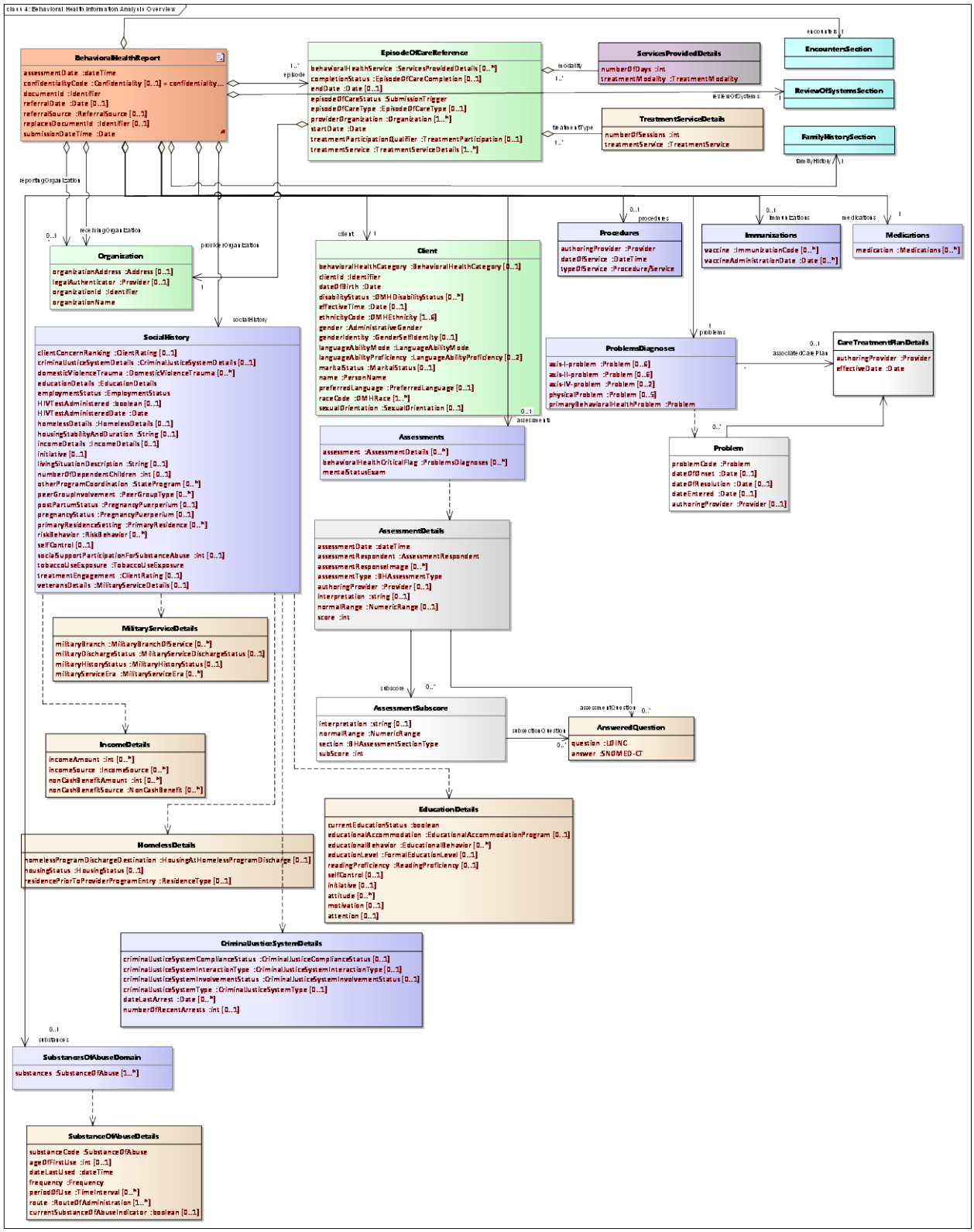

Figure 4: Behavioral Health Information Analysis Overview

Figure 5 depicts the Demographics and Episode of Care domains, data elements and associated value sets.

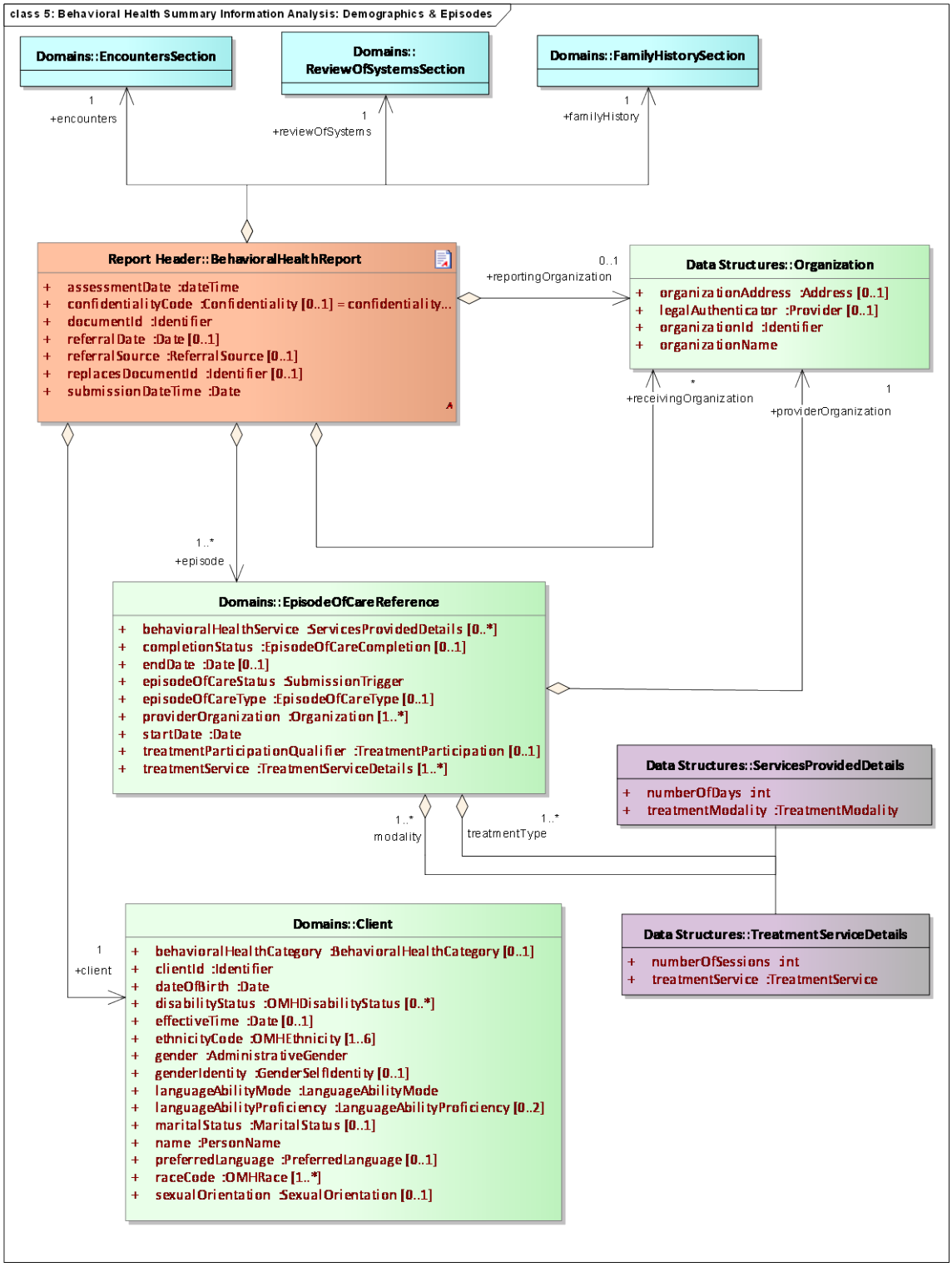

Figure 5: Behavioral Health Summary Information Analysis: Demographics & Episodes

Figure 6 depicts the Social History domains, data elements and associated value sets.

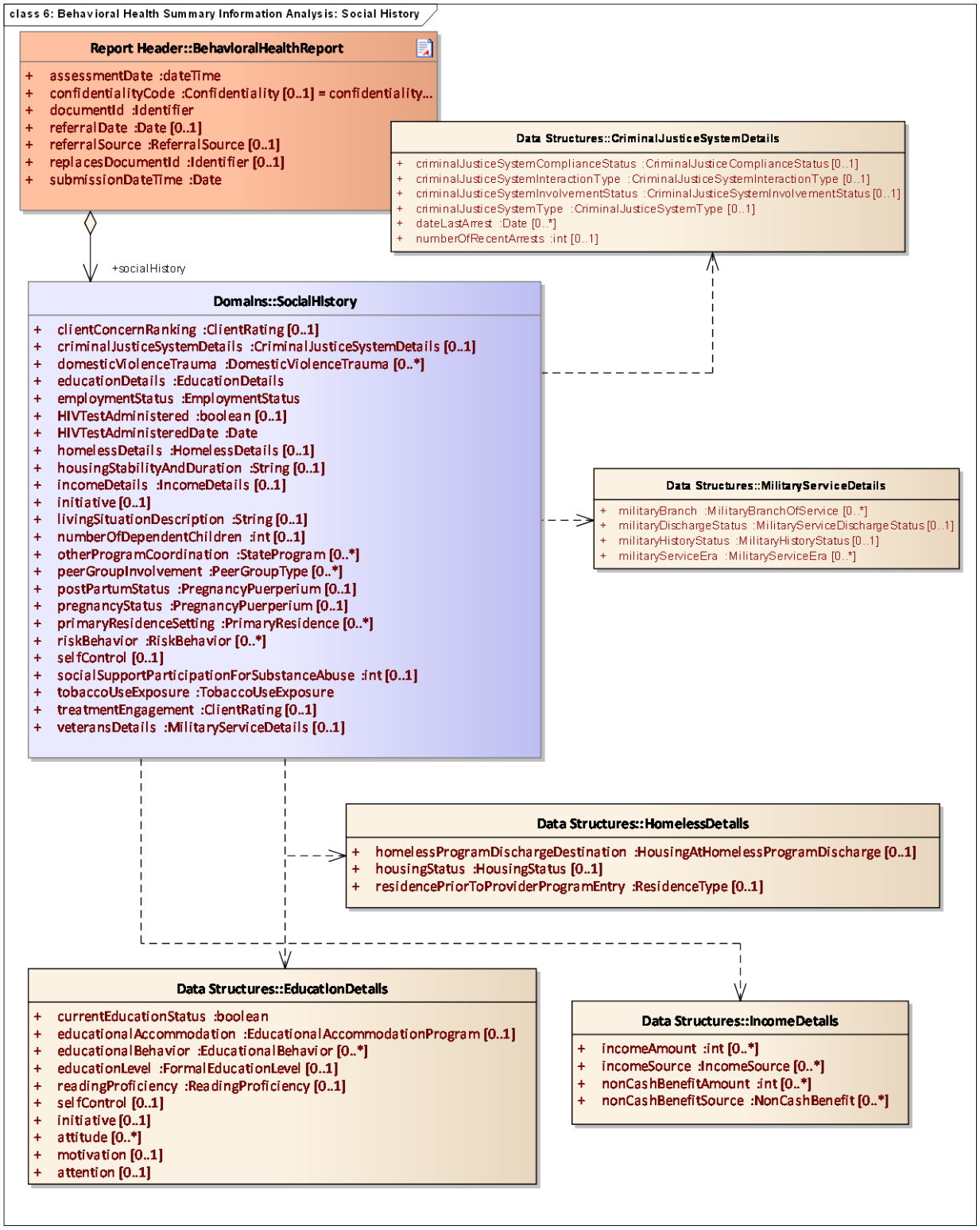

Figure 6: Behavioral Health Summary Information Analysis: Social History

Figure 7 depicts the Procedures, Immunizations and Medications domains, data elements and associated value sets.

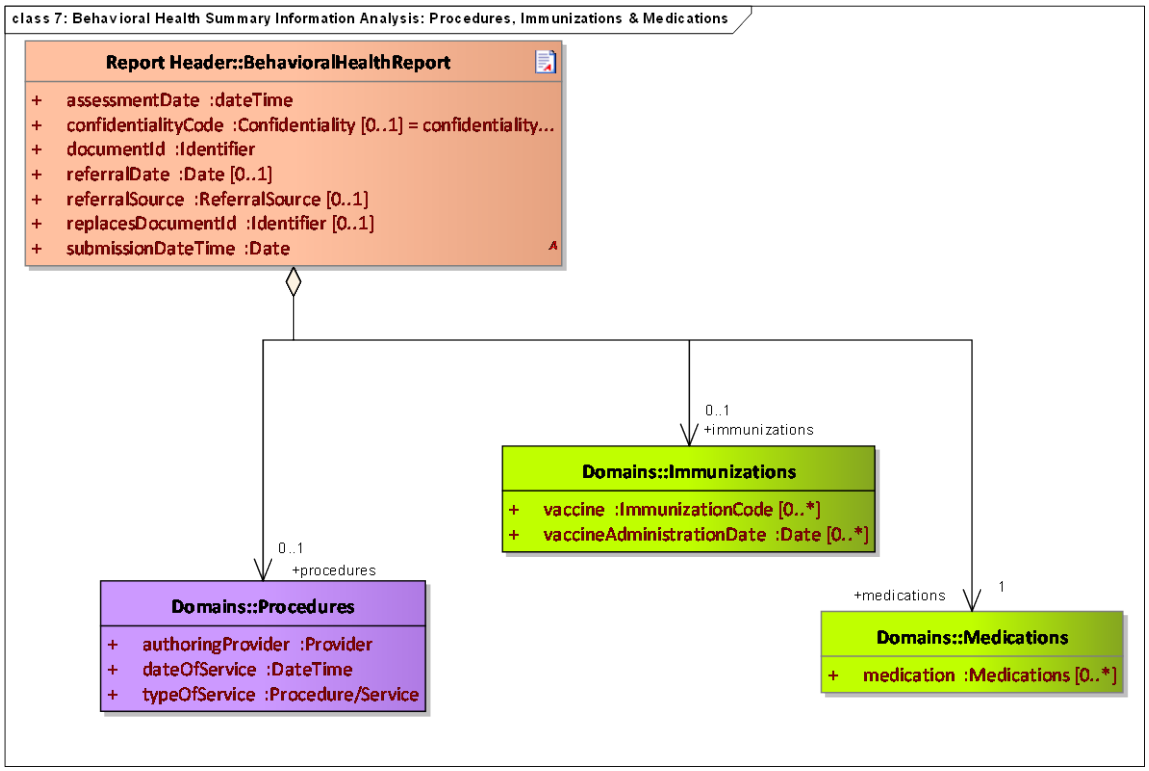

Figure 7: Behavioral Health Summary Information Analysis: Procedures, Immunizations & Medications

1.3.1 Report Header

The following section describes the report header information that allows the document to be managed by a document management system and if necessary, to aggregate related reports for a client.

Figure 8 depicts the Assessment and Problem domains, data elements and associated value sets.

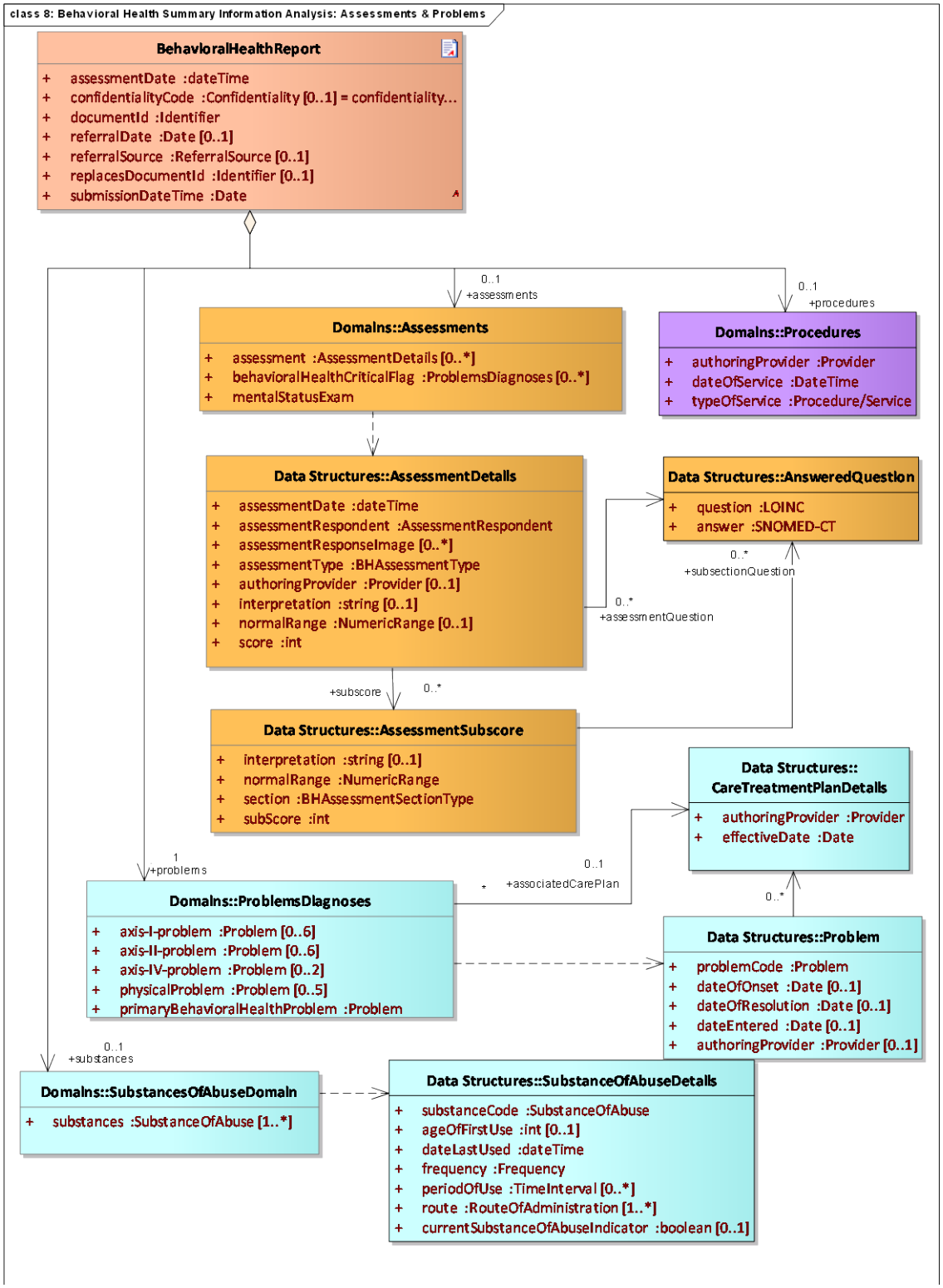

Figure 8: Behavioral Health Summary Information Analysis: Assessments & Problems

1.3.1.1 BehavioralHealthReport

This class represents a summary document for Behavioral Health exchange. For example, this could be in the form of a Continuity of Care document (CCD). It specifies the global characteristics of the record - the date when it was created, submitted, or revised and resubmitted. It contains other information organized into header and sections.

Data Element	Definition
assessmentDate dateTime	The data element is the date the assessment was completed.
confidentialityCode Confidentiality [0..1]	This data element classifies the Behavioral Health report as a restricted report, and uses the Confidentiality value set. Confidentiality represents the privacy metadata indicating the sender's sensitivity classification, which is based on an analysis of applicable privacy policies and the risk of harm that could result from unauthorized disclosure. **confidentialityCode = R**
documentId Identifier	This is the unique identifier for the document instance as specified by the "Identifier" data type.
referralDate Date [0..1]	This data element represents the date when the regional authority or provider received a referral for service. A referral includes an oral, written, faxed or electronic request for services made by the client or on the client's behalf.
referralSource ReferralSource [0..1]	This data element refers to the source of referral for this behavioral health episode of care. Referral source is an administrative concept that is highly correlated with billing, and therefore is appropriate to use for information that is captured at the "point of service" within the normal workflow. As social services become more tightly integrated into the health care delivery process, it may become necessary to enhance the billing code sets currently being used. This data element is used to describe the source of the referral. This element uses the ReferralSource value set.
replacesDocumentId Identifier [0..1]	This identifier specifies the document identifier for the document that is replaced by this document instance as specified by the "Identifier" data type.
submissionDateTime Date	The date the report was submitted.

1.3.2 Domains

The Domains section describes the information required to support the behavioral health use cases described above.

In the Informative 1 Ballot, this information was grouped into classes that were referenced as CDA sections (e.g., Social History, Medications, Procedures, Problems, etc.) However as additional exchange requirements surfaced during this phase of project, the information was organized into

domains, or subject areas of interest, that may be exchanged between information sources other than the health care system (e.g., Criminal Justice System, Educational System, and other social service agency systems).

Each domain and corresponding core data elements are described in the following section:

1.3.2.1 EpisodeOfCareReference

This domain references an episode of care as it appears in a behavioral health report.

An episode of care is defined as the period between the beginning and end of Behavioral Health services treatment for an individual. Within an episode of care, a person may transfer to a different service, facility, program or location. The beginning and end of an episode of care is marked by a demographic file submission. Over time, an individual may have multiple episodes of care. In addition, an episode may represent the start and end of a Crisis event.

Data Element	Definition
behavioralHealthService ServicesProvidedDetails [0..*]	This data element is used to describe information related to the type of services provided during a client's course of treatment/recovery. It uses the ServicesProvided data structure. Information gleaned from sections A & K - SERVICES PLANNED & SERVICES RECEIVED in CSAT GPRA Client Outcome Measures for Discretionary Programs Codebook.
completionStatus EpisodeOfCareCompletion [0..1]	This data element specifies how/why the episode of care was completed. The values allowed in this field are limited to those specified in the "EpisodeCompletionCode" value set.
endDate Date [0..1]	This data element represents the date/time when the episode of care ended. This is an optional data element since the exchange may occur before the end of the episode of care.
episodeOfCareStatus SubmissionTrigger	This data element specifies the reason/trigger for the document submission. It reflects the state of the encounter and type of assessment (e.g. new episode start, full assessment, episode end, crisis and correction/update) at the time the report is transmitted. The state machine specifies details related to the allowed state transitions of a document. The codes for this data element are specified by "SubmissionTrigger" value set.
episodeOfCareType EpisodeOfCareType [0..1]	This data element distinguishes the type of encounter represented by this data exchange: Crisis or Routine. These reports may be treated differently based on the type of encounter by behavioral health programs. It is bound to the EpisodeOfCareType value set. Along with submissionTrigger, this data element qualifies the reason for submission by providing the context of the encounter.
providerOrganization Organization [1..*]	This data element contains information describing the organization delivering Behavioral Health services or that is reporting information about the client's episode of care. The provider organization is described using the "Organization" template described to the right.

Data Element	Definition
startDate Date	This data element is the date/time when the episode of care started.
treatmentParticipationQualifier TreatmentParticipation [0..1]	This data element describes the manner in which a client participates in a Behavioral Health Episode of Care. A client may participate voluntarily, or due to a court order or conditions of parole/probation requiring the client to receive Behavioral Health services. This data element uses the "TreatmentParticipation" value set.
treatmentService TreatmentServiceDetails [1..*]	This data element reflects the type of treatment services provided to Behavioral Health clients. At least one type of treatment service must be associated with the client at intake (admission) and at discharge. This data element uses the TreatmentServiceDetails data structure to convey additional properties associated with each service received during treatment.

1.3.2.2 Client

This domain refers to the client - the person who receives, or has received, Behavioral Health services and contains the core set of demographic information to be exchanged.

Data Element	Definition
behavioralHealthCategory BehavioralHealthCategory [0..1]	This data element is used to classify clients into categories that help identify clients that may be eligible for integrated services coordination. This classification is an optional element that is state-specific and rules-based on various client characteristics such as age, functional impairment category, problems/diagnoses, etc. This data element is derived from information about the client's age, functional impairment category, and problems. In order to be placed into a specific category, the client must have one of the qualifying diagnoses and functional impairment for that age group (e.g. under 18 of age, 18 years and older). The starter BehavioralHealthCategory value set includes five possible designations (i.e., child non-SED, child with SED, adult with SMI, adult non-SMI with general mental health need and adult non-SMI with substance abuse) which are assigned to each client enrolled in the state behavioral health system. The problems that identify Severe Emotional Disturbed and Severely Mentally Ill are drawn in the Severe Emotionally Disturbed and Severely Mentally Ill value sets. In 2012, SAMHSA is sponsoring Primary and Behavioral Health Care Integration (PBHCI) grants. The purpose is to establish projects for the provision of coordinated and integrated services through the co-location of primary and specialty care medical services in community-based mental and behavioral health settings. The goal of this program is to improve the physical health status of adults with serious mental illnesses (SMI) who have or are at risk for co-occurring primary care conditions and chronic diseases, with the objective of supporting the triple aim of improving the health of those with SMI; enhancing the consumer's experience of care (including quality, access, and reliability); and reducing/controlling the per capita cost of care.
clientId Identifier	This is the unique identifier for the client as specified by the "Identifier" data type. A client is the person who receives, or has received, Behavioral Health services.

Data Element	Definition
dateOfBirth Date	This data element is the client's date of birth.
disabilityStatus OMHDisabilityStatus [0..*]	This data element is used to convey information related to the disability status for a Behavioral Health client and uses the "OMHDisabilityStatus" value set.
effectiveTime Date [0..1]	This data element refers to the effective date of any addition or change to the demographic fields of a client. 2478066014 is a child of 118598001 (measurement property) [qualifier value] so this may be the appropriate single code to represent 'effective time'. Alternatively, one could use two SNOMED-CT codes: 410670007 (time) [linkage concept] which is a child of 260863009 (temporal relationship) [linkage concept]
ethnicityCode OMHEthnicity [1..6]	This data element refers to the ethnicity specified by the client and uses the Office of Minority Health data standards-based OMHEthnicityCodeValueSet. This is a required element and more than one ethnicity code may be specified, up to six times.
gender AdministrativeGender	This data element is used to identify the sex of the patient for demographic data collection purposes as well as to provide a high-level classification that can be used for the appropriate allocation of inpatient bed assignment. This element is frequently called 'administrative gender' and uses two HL7 standards-based value sets: HL7 V2 Administrative Sex and HL7 V3 Administrative Gender.
genderIdentity GenderSelfIdentity [0..1]	This data element is used to convey the client's gender identity, otherwise known as core gender identity, and refers to how the client self-identifies. It is not based on the person's anatomy. This data element uses the "GenderSelfIdentity" value set.
languageAbilityMode LanguageAbilityMode	This attribute is used to describe the client's ability with language and uses the LanguageAbilityMode value set.
languageAbilityProficiency LanguageAbilityProficiency [0..2]	This attribute is used to describe the client's proficiency with his / her declared preferred language and uses the LanguageAbilityProficiency value set.
maritalStatus MaritalStatus [0..1]	This data element represents the client's current domestic partnership status and uses the MaritalStatus value set.
name PersonName	This is the client's name as specified in the "PersonName" data type.
preferredLanguage PreferredLanguage [0..1]	This data element reflects the preferred language spoken by the client and uses the "PreferredLanguage" value set. This information is required by the United States Meaningful Use Stage 1 (and above) electronic health record incentive program.
raceCode OMHRace [1..*]	This data element refers to the race specified by the client and uses the Office of Minority Health data standards-based OMHRaceCodeValueSet. This is a required element and more than one race code may be specified.
sexualOrientation SexualOrientation [0..1]	This data element refers to an enduring pattern, or lack thereof, of a romantic, sexual, and/or emotional attraction to men, women, or all genders. This data element uses the "SexualOrientationCode" value set.

1.3.2.3 Assessments

The Assessment domain describes the information recorded and exchanged between providers and state agencies about specific Behavioral Health assessments administered to behavioral health clients. In the original and first iteration of this domain analysis, only scores and sub-scores were intended for exchanged.

In the Informative 1 ballot, only the overall assessment scores and/or section sub-scores were intended for exchange. However, new requirements surfaced during the requirements analysis phase for Informative 2 Ballot related to assessment question and answer pair details.

Data Element	Definition
assessment AssessmentDetails [0..*]	This data element represents details related to assessments administered to behavioral health clients and uses the AssessmentDetails data structure.
behavioralHealthCriticalFlag ProblemsDiagnoses [0..*]	This data element is used to indicate an immediate risk of a critical nature based on the outcome of an overall Assessment. An EHR system may use this data element for decision support. This flag is encoded using behavioralHealthCriticalFlag value set.
mentalStatusExam	This data element is a placeholder for Mental Status Exam.

1.3.2.4 SocialHistory

The Social History domain refers to the information about the client's education, occupation, usual daily activities, functional status, relationships with friends and family, social supports and stresses, financial status/insurance coverage and habits such as use of cigarettes or alcohol that have known health consequences.

This domain may include information that could be exchanged by various agencies, including criminal justice, housing, social service agencies, U.S. or state departments of labor, etc.

Data Element	Definition
clientConcernRanking ClientRating [0..1]	This data element is used to capture a ranking that indicates how much a client reports to be bothered by a specific problem (self-reported). This data element uses the ClientRating value set.
criminalJusticeSystemDetails CriminalJusticeSystemDetails [0..1]	This data element refers to the type of criminal justice system involvement for a client who has been adjudicated guilty (e.g. juvenile probation, adult incarceration, juvenile parole, etc). It uses the CriminalJusticeSystemDetails data structure.
domesticViolenceTrauma DomesticViolenceTrauma [0..*]	This data element represents information about the kind of Violence and/or Trauma that a client may have been exposed to in the past and uses the DomesticViolenceTrauma value set. At the aggregate level, knowing the size of the homeless population that has

Data Element	Definition
	experienced domestic violence is critical for determining the resources needed to address the problem in this population.
educationDetails EducationDetails	This data element is used to represent information that can be expressed about a client's educational status and related details and uses the EducationDetails data structure.
employmentStatus EmploymentStatus	This data element represents client's current employment status. Entry must be ascertained by a clinical professional. This data element uses the "EmploymentStatusCode" value set.
HIVTestAdministered boolean [0..1]	This data element is used to convey whether a client had an HIV test prior to this Behavioral Health episode of care.
HIVTestAdministeredDate Date	This data element is used to convey the date a client took an HIV test prior to this Behavioral Health episode of care.
homelessDetails HomelessDetails [0..1]	This data element is used to express information related to homelessness and uses the HomelessDetails data structure.
housingStabilityAndDuration String [0..1]	This data element is used to describe the client's satisfaction with their current housing situation (livingSituationDescription) and how long they have been living there (e.g., I am happy with my living situation and have been living here for six months).
incomeDetails IncomeDetails [0..1]	This data element is used to represent information related to various sources of income for a client / patient and uses the IncomeDetails data structure.
initiative [0..1]	This element describes a child's ability to independently apply cognitive skills to actively meet his or needs and uses a scalar rating value set.
livingSituationDescription String [0..1]	This data element is used to provide a textual description describing the client's current type of living situation, e.g., alone, with family, group home, etc. Used in conjunction with housingStabilityAndDuration, it can be used to provide a measure of the overall housing status for the client over time. This may become a coded value.
numberOfDependentChildren int [0..1]	This data element identifies clients who have dependent children. The number includes children that have been removed and are in the custody of Child Protective Services. In some states this element may be required.
otherProgramCoordination StateProgram [0..*]	States provide a wide range of services to a small population of people with high needs. This data element indicates whether the client is involved with other programs (e.g. Department of Economic Security - DES, Rehabilitative Services Administration - RSA). This information is used to determine which agency is responsible for payment of behavioral health care services. This data element is needed for the coordination of care. The field identifies agencies that provide services that require coordination with behavioral health services. It uses the "StateProgramCode" value set.
peerGroupInvolvement PeerGroupType [0..*]	This data element is used to describe a client's current participation in peer group support and the duration of involvement with each group. This data element uses the PeerGroupInvolvementDetails data structure.
postPartumStatus PregnancyPuerperium	This data element reflects the current post-partum status (Yes/No) of a female client / patient. A patient is considered post-partum at the time of treatment, up to 6 months from the day of delivery. This data element will be associated with a

Data Element	Definition
[0..1]	value from the PregnancyPuerperium value set as required.
pregnancyStatus PregnancyPuerperium [0..1]	This data element reflects the current pregnancy status (Yes/No) of a female client / patient. This data element will be associated with a value from the PregnancyPuerperium value set as required.
primaryResidenceSetting PrimaryResidence [0..*]	This data element specifies the place where the client spent most of his/her time within the 30 days prior to intake or any change thereafter. This coded data element is constrained by the PrimaryResidence value set.
riskBehavior RiskBehavior [0..*]	This data element is used to represent the client's risk behaviors. It uses the RiskBehavior value set.
selfControl [0..1]	This element describes a client's ability to experience a range of feelings and use of expressive language and uses a scalar rating value set.
socialSupportParticipationForSubstanceAbuse int [0..1]	This data element identifies how many times during the past 30 days the client participated in any self help or recovery group for substance abuse (e.g. Alcoholics Anonymous, Narcotics Anonymous, WRAP/WELL, Recovery Center programming, etc.).
tobaccoUseExposure TobaccoUseExposure	This data element is used to describe the client's use and/or exposure to tobacco and uses the TobaccoUseExposure value set that is mapped to the standards-based SNOMED-CT code system.
treatmentEngagement ClientRating [0..1]	This data element is used to represent the client's willingness to change and participate in a treatment program. This data element uses the ClientRating value set.
veteransDetails MilitaryServiceDetails [0..1]	This data element is used to reflect information that may be captured for Veterans in the U.S. military and uses the VeteranDetails data structure.

1.3.2.5 ProblemsDiagnoses

The ProblemsDiagnoses domain describes information related to the client's problems - behavioral health as well as physical conditions.

The Problem data structure describes additional properties of Problems, including the standards-based code representing the 'problem', the provider who noted the problem/diagnosis, the date problem recorded (likely to be the assessment date), date of onset if known and date of resolution if problem is no longer active.

Meaningful Use Stage 2 requires that problems included in a Problem List section of a CDA document must be exchanged using the SNOMED-CT code system.

Data Element	Definition
axis-I-problem Problem [0..6]	Up to six diagnoses from the DSM-IV Axis I category may be reported in a single encounter. The primaryBehavioralHealthProblem is constrained to a value from either DSM-IV Axis I or Axis II.

Data Element	Definition
axis-II-problem Problem [0..6]	Up to six diagnoses from the DSM-IV Axis II category may be reported in a single encounter. See definition for the primaryBehavioralHealthProblem data element. The primaryBehavioralHealthProblem is constrained to a value from either DSM-IV Axis I or Axis II.
axis-IV-problem Problem [0..2]	Up to two Axis IV conditions may be reported.
physicalProblem Problem [0..5]	The problem may be encoded using SNOMED-CT, ICD-9-CM or ICD-10-CM, depending on the source system and the date of the diagnosis, pursuant to applicable regulations. This data element is used to represents problems typically exchanged in Axis III using a valid DSM-IV TR code. Axis III lists any medical or neurological problems that may be relevant to the client's current or past psychiatric problems; for example, someone with severe asthma may experience respiratory symptoms that are easily confused with a panic attack, or indeed, which may precipitate a panic attack. Up to five Axis III conditions may be reported.
primaryBehavioralHealthProblem Problem	This data element is used to communicate the principal diagnosis or first listed diagnosis (primary diagnosis) for the behavioral health encounter. The principalDiagnosis must be drawn from the AXIS I or AXIS II value sets which by definition consist of valid DSM-IV-TR codes. DSM-IV codes are taken from International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) by reviewing the ICD-9-CM system to select the code that best corresponds to each DSM-IV-TR category to create a crosswalk between DSM-IV TR and ICD-9-CM. The Health Insurance Portability and Accountability Act (HIPAA) requirement for clinicians and hospitals to use ICD-9-CM codes for diagnostic purposes allows clinicians to use the DSM-IV-TR codes in any situation in which a valid ICD-9-CM code is required (e.g., on Medicare and other insurance forms) because each DSM-IV-TR diagnostic code is currently cross-walked to a valid ICD-9-CM code. In late May 2013, DSM-IV TR is scheduled to be replaced by DSM-5. Future work on the domain analysis model will accommodate DSM-5.

1.3.2.6 SubstancesOfAbuseDomain

This domain refers to the section of the Behavioral Health report that specifies the substances of abuse used by the client.

Each substance (of abuse) uses the SubstanceOfAbuseDetails data structure to describe additional properties (e.g., age at first use, frequency, route, date last used, etc.).

Data Element	Definition
substances SubstanceOfAbuse [1..*]	This element specifies the substances of abuse and uses the SubstanceOfAbuseDetails data structure to describe the details collected regarding the client's substance abuse history (including current use). Typically up to three substances may be specified.

1.3.2.7 Medications

The Medications domain describes information related to medications documented for the client during the Behavioral Health episode of care. The type of medication includes prescribed as well as Over-the-Counter Medications (OTC).

This domain uses the Provider data structure to describe additional characteristics of the provider associated with the medication entry including location and provider ID.

This domain may re-use the following sections from Consolidated CDA (C-CDA):

Medications Section With Coded Entries Optional
[2.16.840.1.113883.10.20.22.2.1 (open)]

Medications Section With Coded Entries Required
[2.16.840.1.113883.10.20.22.2.1.1 (open)]

Data Element	Definition
medication Medications [0..*]	This data element is the substance (not of abuse) recorded for client during the episode of care. The code system used to represent this item is **RxNorm** (which supports prescription and over the counter medications) and uses the Medications value set.

1.3.2.8 Procedures

The Procedures domain is used to convey information about the procedures/services (behavioral health or physical/medical) that has been provided to Behavioral Health client during a Behavioral Health episode of care.

Data Element	Definition
authoringProvider Provider	This data element is the provider who rendered the procedure/service. The provider's identifying traits are represented using the "Provider" data structure.
dateOfService DateTime	This data element is the date/time that the procedure or service was rendered to the client.
typeOfService Procedure/Service	This data element represents the standards-based coded value for procedure/service provided to the client during the course of treatment. The value set may be drawn from the "Procedure" value set.

1.3.2.9 Immunizations

The Immunization domain describes information about the vaccinations which are indicated or have been received by the client during an episode of care. This domain has not been fully analyzed at the time of ballot.

Data Element	Definition
vaccine ImmunizationCode [0..*]	This data element contains the standards-based code for the immunization that has been received or administered to the client / patient. It uses the ImmunizationCode value set.
vaccineAdministrationDate Date [0..*]	This represents the date the vaccine was administered.

1.3.2.10 EncountersSection

The Encounters Section describes the healthcare encounters pertinent to the patient's current health status or historical health history.

An Encounter is an interaction, regardless of the setting, between a patient and a practitioner who is vested with primary responsibility for diagnosing, evaluating, or treating the patient's condition. It may include visits, appointments, as well as non-face-to-face interactions.

This section may contain all encounters for the time period being summarized, but should include notable encounters.

This section will reuse two Consolidated CDA templates:
(Encounters with coded entries optional: 2.16.840.1.113883.10.20.22.2.22)
(Encounters with coded entries required:
2.16.840.1.113883.10.20.22.2.22.1)

1.3.2.11 FamilyHistorySection

The Family history section is used to exchange information related to a client's family history of mental health, substance abuse, suicide related issues.

This section will re-use the Consolidated CDA template:
(Family History Section 10157-6: 2.16.840.1.113883.10.20.22.2.15).

1.3.2.12 ReviewOfSystemsSection

The Review of Systems section contains a relevant collection of symptoms and functions systematically gathered by a clinician. It includes symptoms the patient is currently experiencing, some of which were not elicited during the history of present illness, as well as a potentially large number of pertinent negatives, for example, symptoms that the patient denied experiencing.

This section will re-use the Consolidated CDA template: (Review of Systems Section 10187-3: [1.3.6.1.4.1.19376.1.5.3.1.3.18).

1.3.3 Data Structures

Figure 9 depicts the data structures reused by various actors during information exchange involving behavioral health clients.

A common understanding of the content exchanged between behavioral health care providers and community service providers involved in the care or custody of behavioral health clients is critical to ensure interoperability between these entities. These structures describe how these data should be represented including the code systems and value sets used in exchange so that there is semantic interoperability across previously siloed providers and agencies.

These data structures are described in detail following Figure 9.

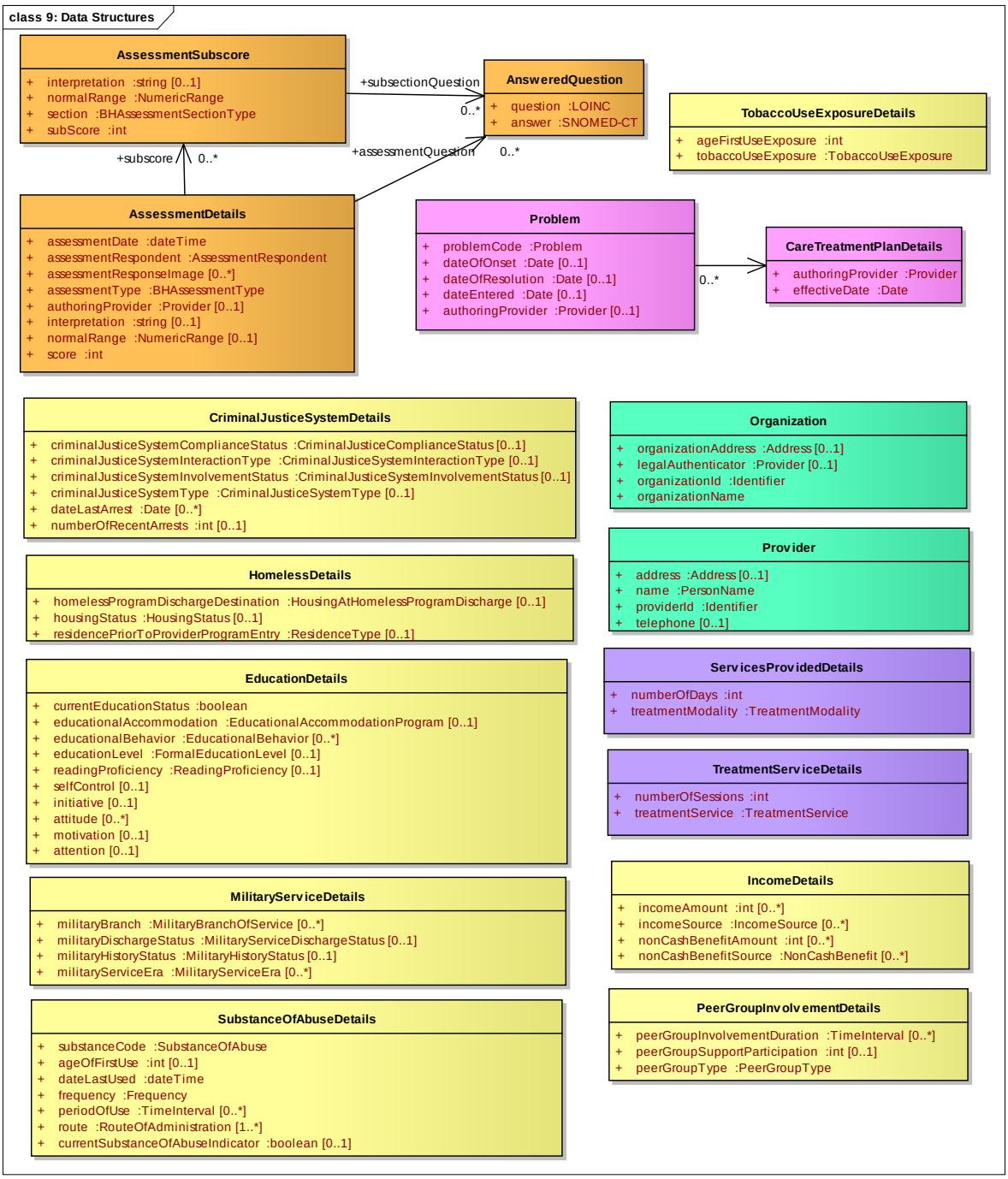

Figure 9: Data Structures

1.3.3.1 AssessmentDetails

AssessmentDetails describes the information recorded and exchange between providers and state agencies about the type and overall score of an assessment administered to a behavioral health client. This class is associated with a sub-score or a set of questions.

This model allows for the exchange of questions associated with a standardized assessment instruments or a specific sub-section of a standardized assessment instrument.

Data Element	Definition
assessmentDate dateTime	This data element identifies the date/time when the assessment was administered.
assessmentRespondent AssessmentRespondent	This data element is used to capture the type of person who responded to an assessment instrument, whether this is clinician administered or self-report assessment. This is because the respondent may not be the target of the assessment (e.g., parent responding for child, etc.). This data element uses the AssessmentRespondent value set.
assessmentResponseImage [0..*]	This data element is used to exchange graphical responses to the Assessment. It includes drawings, image files (Mini-Mental State Examination (MMSE) may have a LOINC code). This optional element will be in addition to any score/interpretation exchanged. The implementers will use establish mechanisms for exchanging images.
assessmentType BHAssessmentType	This data element identifies the type of assessment that was applied to the client and is intended to be specified using a LOINC code and uses the BHAssessmentType value set.
authoringProvider Provider [0..1]	This data element identifies clinician who administered the assessment - the provider's identifying traits are represented using the "Provider" data structure.
interpretation string [0..1]	This optional data element specifies the clinical interpretation of the score. This may be included - as an optional element of a report especially if the receiving organization (i.e. the provider that receives the client into their care) does not use the exact scoring tool.
normalRange NumericRange [0..1]	This data element represents the numeric range of assessment scores that are considered to be the "average or normal range".
score int	This numeric data element specifies the overall score of the assessment.

1.3.3.2 AssessmentSubscore

AssessmentSubscore describes the information used to convey results from a section of a standardized Assessment instrument containing subscore(s).

Data Element	Definition
interpretation string [0..1]	This optional data element specifies the clinical interpretation of the subscore. This may be included - as an optional element of a report especially if the receiving organization (i.e. the provider that receives the client into their care) does not use the exact scoring tool.

Data Element	Definition
normalRange NumericRange	This data element represents the numeric range of assessment scores that are considered to be the "average or normal range".
section BHAssessmentSectionType	This data element contains code that corresponds to the particular section of a standardized assessment instrument that produces a subscore result. The assessment section will be encoded as LOINC for interoperability using the BehavioralHealthAssessmentSectionTypeCode value set. During the next phase of this project, we will conduct a terminology mapping process that will produce a proposed starter value set enumerating a core list of assessments. The mapping process will result in a gap analysis which likely will lead to New Term Request and/or Change to Existing Term proposals for LOINC.
subScore int	This data element is the subscore value for a section of a specific standardized assessment.

1.3.3.3 AnsweredQuestion

AnsweredQuestion contains the information related to the questions and answers included in an assessment and/or assessment subsection.

Data Element	Definition
question LOINC	This data element is the coded question in the standard assessment instrument. It is assumed that each question will be encoded in LOINC. The assessment instrument itself is encoded in LOINC, and will be represented as a panel or battery containing the individual questions encoded as LOINC answers.
answer SNOMED-CT	This data element is the coded answer to the assessment question. It is assumed this element will be drawn from the SNOMED-CT clinical finding hierarchy.

1.3.3.4 CareTreatmentPlanDetails

CareTreatmentPlanDetails describes information related to the care or treatment plan for a behavioral health client. The care treatment plan may be associated with a particular problem in the problem list.

- The data/time of the care plan and other information may be relevant for reporting and continuity/transfer of care.
- During analysis, we established that the treatment/care plan needs to be associated with problem list but we do not have detailed requirements regarding this association.
- We also established that the Care or Treatment plans must be based on best-practices and evidence. This research or evidence may be referenced in conjunction with the care plan.

Data Element	Definition
authoringProvider Provider	This data element is the provider who created or last updated the Care Treatment Plan. This data element uses the Provider template.

Data Element	Definition
effectiveDate Date	The data element is the date the care treatment plan was created or last updated for a client.

1.3.3.5 CriminalJusticeSystemDetails

This data structure is used to convey information about behavioral health client involvement with the criminal justice system including the type of criminal justice system (e.g. adult, juvenile) and status (e.g. probation, incarceration, or parole). The intent is to include information that can be used to track a client's compliance in the criminal justice system.

Changes in this status over time may be indicative of positive outcomes and the effective treatment delivered by providers for those incarcerated during an episode of care.

Data Element	Definition
criminalJusticeSystemComplianceStatus CriminalJusticeComplianceStatus [0..1]	This data element describes the attendance or measurable compliance with criminal justice system (parole or pre-trial events). This information is intended to come from a case worker / criminal justice system and uses the CriminalJusticeComplianceStatus value set.
criminalJusticeSystemInteractionType CriminalJusticeSystemInteractionType [0..1]	This data element represents the type of interaction a client may have had with a criminal justice system and uses the CriminalJusticeSystemInteractionType value set. Behavioral Health information systems generally do not capture a great deal of arrest history information, but this information could be electronically communicated by the state systems. The exchange of such data may be subject to privacy protection.
criminalJusticeSystemInvolvementStatus CriminalJusticeSystemInvolvementStatus [0..1]	This data element is used to specify whether the client is incarcerated, paroled, or on probation. This data element uses the "CriminalJusticeSystemInvolvementStatus" value set.
criminalJusticeSystemType CriminalJusticeSystemType [0..1]	This data element specifies whether the client is in the juvenile or adult criminal justice system since client age cannot be used to make this determination. Juvenile clients may be under adult criminal justice system jurisdiction. This data element uses the "CriminalJusticeSystemType" value set.
dateLastArrest Date [0..*]	This data element represents the date(s) the client was last arrested.
numberOfRecentArrests int [0..1]	The number of times the client has been arrested within the last 30 days.

1.3.3.6 EducationDetails

EducationDetails contains the kind of information that could be shared between behavioral health and physical medicine providers with state educational systems to help identify at-risk youth so they can be referred to resources and provided with appropriate services and programs.

Data Element	Definition
currentEducationStatus boolean	This data element describes whether the client is currently enrolled in school (Yes/No) and is intended to reflect the concept of "Currently Attending School".
educationalAccommodation EducationalAccommodationProgram [0..1]	This data element is used to answer the question: "Is the client receiving special education services through an Individual Education Program (IEP) or accommodation through a 504 Accommodations through a 504 Accommodation Plan at his/her school?" This classification is an optional element that is state-specific. Section 504 of the Americans with Disabilities Act (ADA) details the rights children have to an Individualized Education Program (IEP). If a child is placed in a residential treatment facility and receives education at the facility, the child's new school must comply with Section 504 – including providing the accommodations detailed in the child's IEP, reviewing the child's IEP within 30 days of the transfer, notifying the child's parents in writing before the review… This data element is needed at the State level to assure that children are receiving appropriate educational accommodations and to comply with the Americans with Disabilities Act. The EducationalAccommodationProgram value set includes a set of example values for this purpose.
educationalBehavior EducationalBehavior [0..*]	This data element is used to represent the client's educational behavioral issues and uses the EducationalBehavior value set.
educationLevel FormalEducationLevel [0..1]	This data element specifies the highest level of formal education that has been achieved by the client and uses the "FormalEducationLevel" value set.
readingProficiency ReadingProficiency [0..1]	This data element represents the client's ability to read and uses the ReadingProficiency value set. This information may come from the Educational system, or the source may be self-report or assessment-based.
selfControl [0..1]	This element describes a client's ability to experience a range of feelings and use of expressive language and uses a scalar rating value set.
initiative [0..1]	This element describes a child's ability to independently apply cognitive skills to actively meet his or needs and uses a scalar rating value set.
attitude [0..*]	An attitude can be defined as a positive or negative evaluation of people, objects, event, activities, ideas, or just about anything in your environment, but there is debate about precise definitions. Eagly and Chaiken, for example, define an attitude "a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor. This element uses the Attitude value set.
motivation [0..1]	Motivation is a psychological feature that arouses an organism to act towards a desired goal and elicits, controls, and sustains certain goal directed behaviors. It can be considered a driving force; a psychological drive that compels or reinforces an action toward a desired goal. For example, hunger is a motivation that elicits a desire to eat. Motivation has been shown to have roots in physiological, behavioral, cognitive, and social areas. Motivation is an inner drive to behave or act in a certain manner. These inner conditions such as wishes, desires, goals, activate to move in a particular direction in behavior.
attention [0..1]	Attention is a concept studied in cognitive psychology that refers to how we actively process specific information present in our environment. Attention refers to the element of cognitive functioning in which the mental focus is maintained on a specific issue, object, or activity. This element has not yet been fully analyzed nor has a suggested value set been

Data Element	Definition
	proposed.

1.3.3.7 HomelessDetails

This data structure describes information that can be exchanged between Behavioral Health systems and the Homeless Management Information System Initiative (HMIS).

Data Element	Definition
homelessProgramDischargeDestination HousingAtHomelessProgramDischarge [0..1]	This data element is used to describe where the client will be staying after they leave the Homeless program. From Homeless Management Information System, field 4.10 Destination element. This data element uses the HousingAtHomelessProgramDischarge value set.
housingStatus HousingStatus [0..1]	This data element is used by programs that serve homeless and non-homeless persons to separate these two populations for reporting purposes. This element is not intended to be used for program eligibility determination purposes, as program eligibility criteria may vary by program and/or funding source. The associated HousingStatus value set is used to identify persons who, at entry and exit from a Homeless program, are literally homeless; housed, but at imminent risk of losing their housing; housed, but at-risk of losing their housing; or in a stable housing situation.
residencePriorToProviderProgramEntry ResidenceType [0..1]	This data element describes the type of residence just prior to (i.e., the night before) provider program admission. This element uses the PriorResidenceType value set.

1.3.3.8 IncomeDetails

IncomeDetails is used to represent the source and amount of income that a client receives, including cash and non-cash benefits.

Data Element	Definition
incomeAmount int [0..*]	This data element is the amount of income earned by a client associated with a particular incomeSource within the last 30 days.
incomeSource IncomeSource [0..*]	This data element describes the source of a client / patient's income in the past 30 days. More than one source of income may be specified. This data element uses the IncomeSource value set.
nonCashBenefitAmount int [0..*]	This data element describes the amount associated with each source for Non-Cash Benefits that may be received by clients.
nonCashBenefitSource NonCashBenefit [0..*]	Non-cash benefits are important to determine whether clients are accessing all mainstream program benefits for which they may be eligible and to ascertain a more complete picture of their economic circumstances. This information is needed to complete Annual & Quarterly Progress Reports for Housing and Urban Development (HUD) funded Continuum of Care (CoC) Programs, including Homeless Prevention and Rapid Re-Housing (HPRP) programs. This data element uses the NonCashBenefit value set.

1.3.3.9 MilitaryServiceDetails

This data structure describes information about clients who are veterans of the United States.

Data Element	Definition
militaryBranch MilitaryBranchOfService [0..*]	This data element reflects the branch of service in which the veteran is/was enrolled. This data element uses the MilitaryBranchOfService value set.
militaryDischargeStatus MilitaryServiceDischargeStatus [0..1]	This data element reflects the discharge status of a client who is veteran of the military. This data element uses the MilitaryServiceDischargeStatus value set.
militaryHistoryStatus MilitaryHistoryStatus [0..1]	This data element represents the current status within the United States Military for the client / patient. This data element uses the MilitaryHistoryStatus value set.
militaryServiceEra MilitaryServiceEra [0..*]	This data element is used to convey the service era in which the veteran last served. This data element uses the MilitaryServiceEra value set.

1.3.3.10 Organization

The Organization data structure describes information about the organization, agency or entity that delivers services to Behavioral Health clients or that is reporting information about a behavioral health client.

Data Element	Definition
organizationAddress Address [0..1]	This is the address of the organization. While it is not currently specified as a requirement, it may need to be supported to enable interoperability. It is represented using the "Address" data type.
legalAuthenticator Provider [0..1]	This data element identifies the provider who authenticates the content of the report on behalf of the custodian organization using the "Provider" structure.
organizationId Identifier	This is the unique identifier for the reporting organization. It includes the assigning authority (e.g. state, national agency) as defined by the "Identifier" data type.
organizationName	This is the organization's name.

1.3.3.11 PeerGroupInvolvementDetails

PeerGroupInvolvementDetails describes a client's current participation in peer group support and the duration of involvement with each support group. The number of times a client has participated in the past 30 days for each group is also captured.

Data Element	Definition
peerGroupInvolvementDuration TimeInterval [0..*]	This data element reflects the amount of time the client has been participating in a particular peer group support type (peerGroupType).

Data Element	Definition
peerGroupSupportParticipation int [0..1]	This data element identifies how many times during the past 30 days the client participated in any peer group type support.
peerGroupType PeerGroupType	This data element is used to describe the type of peer support group (e.g. veteran peer group) in which the client is currently participating. This data element uses the PeerGroupType value set.

1.3.3.12 Problem

The Problem data structure describes relevant information related to each problem asserted for the behavioral health client that is expected to be exchanged.

Data Element	Definition
problemCode Problem	This data element describes the diagnoses (e.g. principal diagnosis, axis-I-problem, axis-Ii-problem, axis-IV-problem, axis-V-problem, physical Problem, etc.) for a behavioral health client and can be used to express behavioral and/or physical health problems. This element draw its values from a standards-based "Problem" value set based on the exchange requirements (e.g., representing Problems in a Problem List for exchange will use SNOMED-CT, whereas for billing, ICD, CPT /HCPCS (Healthcare Common Procedure Coding System), DSM, etc. code systems are appropriate). The take-away from the discussion around this element is that Problem can be captured in an EHR-S during the clinical documentation process using values from one code system (i.e., SNOMED-CT) and then used during the exchange of a Summary Document such as CCD. This element can also be re-used for billing purposes and exchanged in the appropriate required format (ICD, CPT, HCPCS, etc.) using a terminology service.
dateOfOnset Date [0..1]	This data element represents the date the problem was identified.
dateOfResolution Date [0..1]	If the problem was resolved (no longer active), this data element reflects the date the problem was marked inactive.
dateEntered Date [0..1]	This data element specifies the date the problem was recorded.
authoringProvider Provider [0..1]	This optional data element specifies the provider who made the diagnosis and uses the "Provider" data structure.

1.3.3.13 Provider

The Provider data structure describes information about the individual provider referenced in the client's Behavioral Health summary.

Data Element	Definition
address Address [0..1]	Provider's address - optional. It is represented using the "Address" data type.
name PersonName	This is the provider's name using the "PersonName" data type.

Data Element	Definition
providerId Identifier	This contains the individual provider's identifier (e.g. National Provider ID (NPI) or other unique identifier for providers who are not eligible for an NPI). It uses the "Identifier" data type.
telephone [0..1]	Provider's telephone number.

1.3.3.14 ServicesProvidedDetails

ServicesProvidedDetails contains information related to treatment services planned for Behavioral Health clients. Treatment modality is intended to be captured at the time of admission and at time of discharge, the number of days associated with that treatment modality is captured.

Source: Sections A & K- SERVICES PLANNED & SERVICES RECEIVED from CSAT GPRA Client Outcome Measures for Discretionary Programs Codebook.

Data Element	Definition
numberOfDays int	This is the number of days the service was provided to the client. To be submitted only at discharge.
treatmentModality TreatmentModality	This is the code for the type of services planned for a Behavioral Health client. Example values gleaned from sections A & K - SERVICES PLANNED & SERVICES RECEIVED in CSAT GPRA Client Outcome Measures for Discretionary Programs Codebook. This element is only collected upon "admission" and uses the TreatmentModality value set.

1.3.3.15 SubstanceOfAbuseDetails

SubstanceOfAbuseDetails describes the information related to each substance of abuse recorded for the client. (Information may be recorded for an unlimited number of substances).

Data Element	Definition
substanceCode SubstanceOfAbuse	This data element specifies the substance of abuse using a standard code specified in the SubstanceOfAbuse value set.
ageOfFirstUse int [0..1]	This numeric field specifies the age of the client when the client started using the substance of abuse.
dateLastUsed dateTime	This is the date that the client reports to have last used this substance of abuse.
frequency Frequency	This field specifies the frequency of use of the substance of abuse using the "Frequency" data type (number of times used per unit of time). During the first iteration of this Domain Analysis Model, this element was specified as a coded value using the "FrequencyOfUseCode" value set no longer used.
periodOfUse TimeInterval [0..*]	This data element represents an interval of time in which the client reports to have used the substance. More than one interval of time may be reported.
route RouteOfAdministration [1..*]	This is the route of administration that the client uses for the substances of abuse and is a coded field using the "RouteOfAdministrationCode" value set.

Data Element	Definition
currentSubstanceOfAbuseIndicator boolean [0..1]	This data element is used to indicate that this substance is currently being used by the client.

1.3.3.16 TobaccoUseExposureDetails

TobaccoUseExposureDetails is used to collect information about a client's tobacco use – current as well as past history and age of first exposure.

Data Element	Definition
ageFirstUseExposure int	This data element specifies the age the client first used or was exposed to tobacco in any form.
tobaccoUseExposure TobaccoUseExposure	This data element is used to describe the client's use and/or exposure to tobacco and uses the TobaccoUseExposure value set that is mapped to the standards-based SNOMED-CT code system.

1.3.3.17 TreatmentServiceDetails

TreatmentServiceDetails conveys information related to the types of treatment service(s) provided to a Behavioral Health client. Some of this information may only be captured at time of Intake (admission), Assessment Update and/or discharge.

Information gleaned from sections A & K- SERVICES PLANNED & SERVICES RECEIVED in CSAT GPRA Client Outcome Measures for Discretionary Programs Codebook.

Data Element	Definition
numberOfSessions int	This data element reflects the number of sessions associated with the treatment service provided to the client during the client's course of treatment/recovery.
treatmentService TreatmentService	This is the code for the type of treatment service provided to a Behavioral Health client. The example values are gleaned from CSAT GPRA Client Outcome Measures for Discretionary Programs Codebook. This uses the TreatmentService value set.

1.3.4 Data Types

Figure 10 depicts the data types used to encode the contents of a used to encode the contents of a Behavioral Health Summary record. These data types are described in the following section.

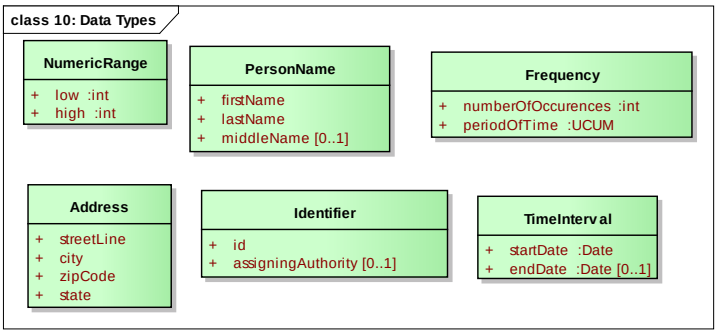

Figure 10: Data Types

1.3.4.1 Address

This class is used to specify the structure of an address.

Data Element	Definition
streetLine	This field holds the street address. SNOMED-CT: 1777663014 (street address) [observable entity]
city	This field holds the city name. SNOMED-CT: 2770657016 (city of residence) [observable entity]
zipCode	This field holds the postal/zip code. SNOMED-CT: GAP however there is patient specific zip code: 1784798016 patient zip code
state	This field holds the state postal code. SNOMED-CT: 224037005 (region of United States of America) [geographic location]

1.3.4.2 Frequency

This class specifies how many times something occurs over a predefined period of time.

Data Element	Definition
numberOfOccurences int	This data element specifies the number of times an event occurs. SNOMED-CT: 263528008 (measurement frequency) [linkage concept]
periodOfTime UCUM	This data element specifies minutes, hours, days, weeks, etc. SNOMED-CT: 282363004 (denominators of time) [qualifier value]

1.3.4.3 Identifier

This class is used to specify the structure of an identifier intended to associate the authority or jurisdiction that issued the identifier.

Data Element	Definition
id	This field holds the value of the identifier. SNOMED-CT: 118522005 (identifier - property) [qualifier value]
assigningAuthority [0..1]	This field holds the authority/jurisdiction that issued the identifier. This may be a provider, a state agency, a federal agency (e.g. Social Security Administration).

1.3.4.4 NumericRange

This class is used to specify minimum and maximum values.

Data Element	Definition
low int	This field contains the low range integer value. SNOMED-CT: 62482003 (low) [qualifier value]
high int	This field contains the high range integer value. SNOMED-CT: 75540009 (high) [qualifier value]

1.3.4.5 PersonName

This class specifies the structure of a person's name. For client name, only first and last name are specified in the current requirements.

Data Element	Definition
firstName	Person's first name SNOMED-CT: GAP except for patient specific code: SNOMED-CT: 2164240014 (patient first name) [observable entity]
lastName	Person's last name SNOMED-CT: GAP except for patient specific code: SNOMED-CT: (184096005 patient surname) [observable entity]
middleName [0..1]	Person's middle name or initial SNOMED-CT: GAP except for patient specific code: SNOMED-CT: 405622006 (patient middle name) [observable entity]

1.3.4.6 TimeInterval

This class refers to an interval of time.

Data Element	Definition
startDate Date	This data element is the start date/time of the interval. SNOMED-CT: 1777755017 (start time) [qualifier value]

Data Element	Definition
endDate Date [0..1]	This data element is the end date/time of the interval. SNOMED-CT: 397898000 (stop time) [qualifier value]

1.3.5 Value Set Analysis

Figures 11 through 15 depict the representative (starter) concepts recommended for interoperable exchange of encoded information in a Behavioral Health summary document.

Many of these concepts will be mapped to standards-based code systems and/or specific value set based on Meaningful Use criteria and mandated HIPAA transaction code systems. Suggested mappings to standards-based code systems can be found in Annex C: Value Set Recommendations.

For concepts that cannot be mapped to standards-based codes, change requests will be submitted once consensus has been reached on the proposed starter sets.

Figure 11 depicts the value sets used by demographic and encounter coded data elements.

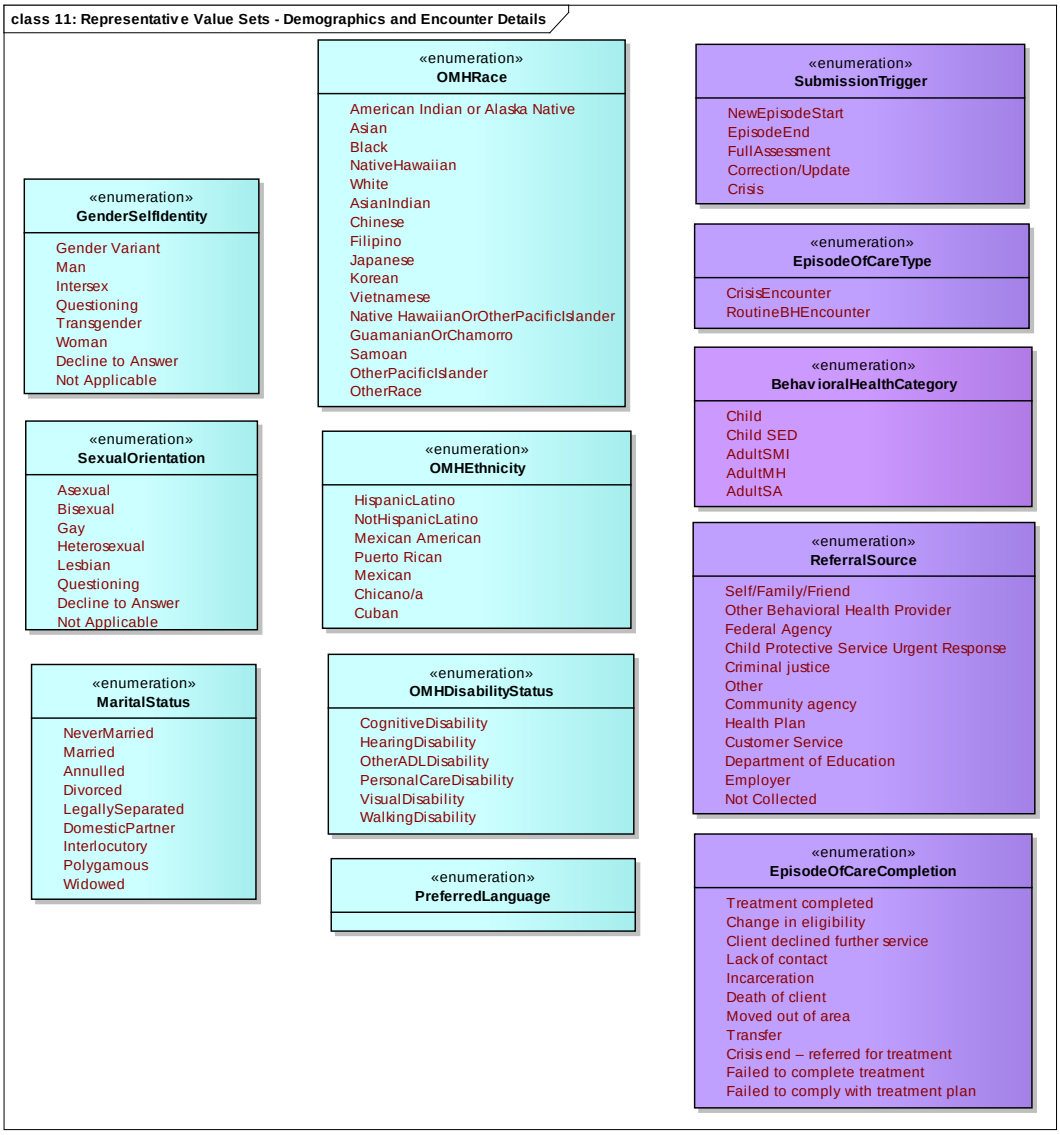

Figure 11: Representative Value Sets - Demographics and Encounter Details

Figure 12 represents the value sets related to behavioral health assessments and recording substances of abuse information.

Figure 12: Representative Value Sets - Behavioral Health Assessment and Substances of Abuse

Figure 13 depicts the value sets related to Residence, Criminal Justice and other social history related details found in the social history section of a summary document.

Figure 13: Representative Value Sets - Social History Details

Figure 14 contains the value sets related to Education, Employment, Income and Veterans details found in the social history section of a summary document.

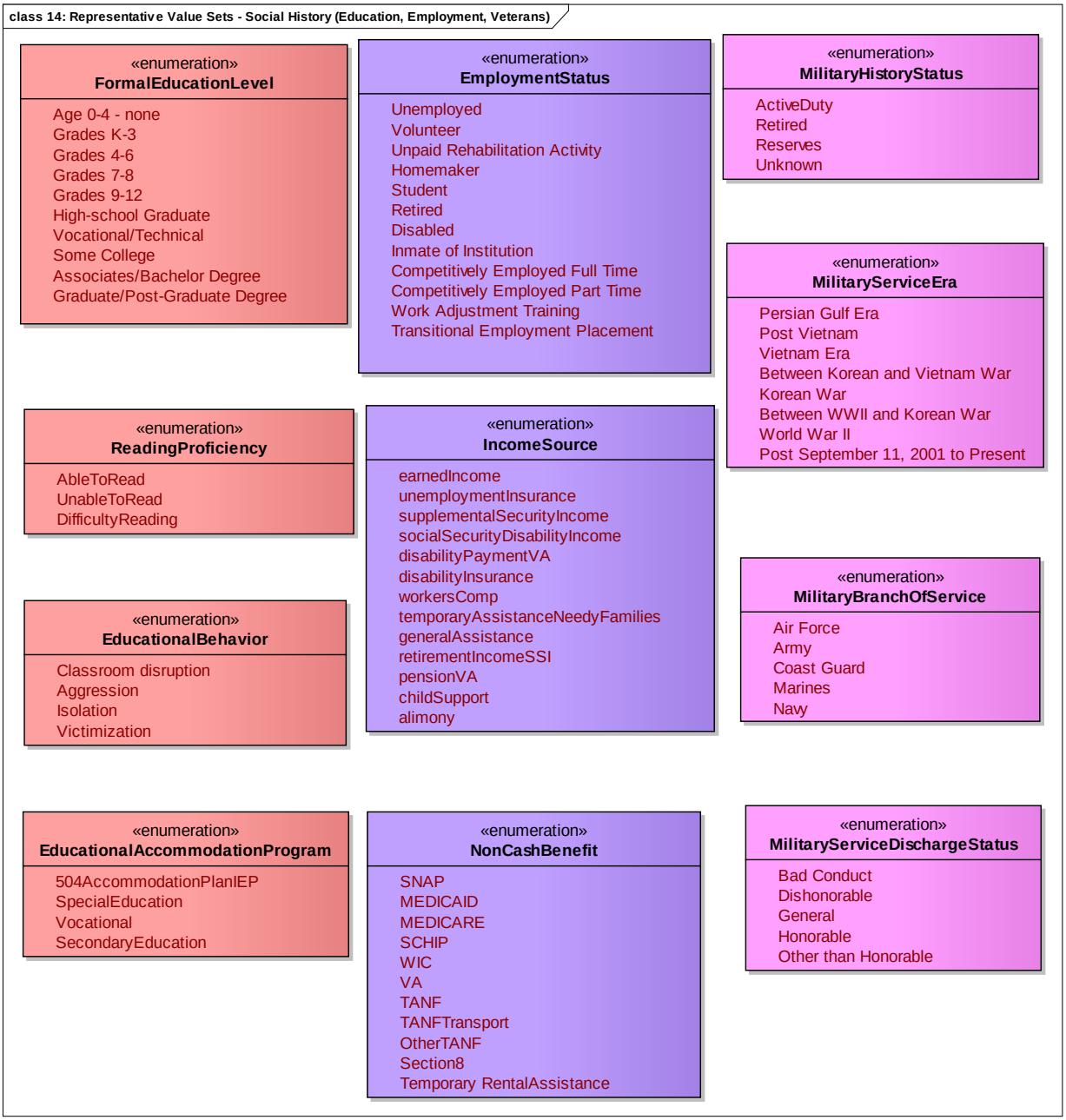

Figure 14: Representative Value Sets - Social History (Education, Employment, Veterans)

Figure 15 represents the suggested items for a variety of value sets related to Problems.

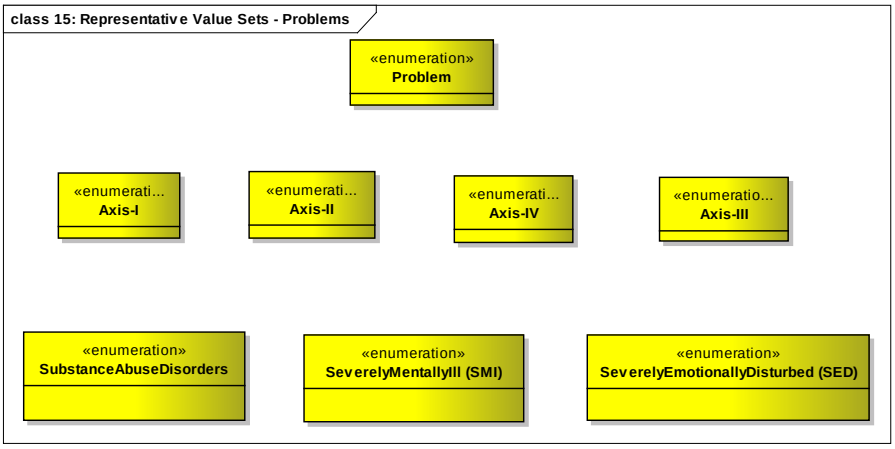

Figure 15: Representative Value Sets - Problems

1.3.5.1 AdministrativeGender

The AdministrativeGender value set is used to specify the gender of a person for administrative purposes as opposed to the clinical gender of a person.

Data Element	Definition
Female	Female
Male	Male
Undifferentiated	Undifferentiated. This enumeration reflects the HL7 Version 3 AdministrativeGender standards-based code system value, defined as the gender of a person could not be uniquely defined as male or female, such as hermaphrodite. There is no value 'Unknown' in the HL7 V3 AdministrativeGender value set.

1.3.5.2 AssessmentCriticalFlag

The AssessmentCriticalFlag value set is used to identify the immediate risk of a critical nature.

Data Element	Definition
suicidalBehavior	This flag is turned on by the provider to indicate that the client is exhibiting suicidal behavior.
homicidalBehavior	This flag is turned on by the provider to indicate that the client is exhibiting homicidal behavior.
atRiskForViolence	This flag is turned on by the provider to indicate that the client is at risk for being violent or violence directed against them.
atRiskForSelfDirectedViolence	This flag is turned on by the provider to indicate that the client is at risk for self-directed violence.

Data Element	Definition
atRiskForSelfMutilation	This flag is turned on by the provider to indicate that the client is at risk for self-mutilation.
atRiskViolenceInHome	This flag is turned on by the provider to indicate that the client is at risk violence in the home.

1.3.5.3 AssessmentRespondent

This value set identifies the type of person who responded to an assessment instrument, whether this is clinician administered or self-report assessment. This is captured because the respondent may not be the target of the assessment (e.g., parent responding for child, etc.).

Data Element	Definition
self	Self/Client - target of the assessment
parent	Parent
careGiver	Care Giver
authority	Authority
spousePartner	Spouse or domestic partner
other	Other point of contact without any biological reason. "Other" may be used if the response is not relevant. It may mean "distant enough that the client"
extendedFamilyMember	Extended Family Member

1.3.5.4 Attitude

This value set is used to describe a client's attitude. Attitude

Data Element	Definition
positiveAttitude	Client has a positive attitude.
negativeAttitude	This client has a negative attitude.

1.3.5.5 Axis-I

This value set contains Axis I codes.

In DSM-IV TR, Axis I refers broadly to the principal disorder that needs immediate attention; e.g., a major depressive episode, an exacerbation of schizophrenia, or a flare-up of panic disorder. It is usually (though not always) the Axis I disorder that brings the person "through the office door."

1.3.5.6 Axis-II

Axis II is used for coding personality and developmental disorders such as mental retardation. Axis II disorders, if present, are likely to influence Axis I problems. For example, a student with a learning disability may become extremely stressed by school and suffer a panic attack (an Axis I diagnosis).

On Axis II, we indicate the personality disorder that may be shaping the current response to the Axis I problem. Axis II also indicates any developmental disorders, such as mental retardation or a learning disability that may be predisposing the person to the Axis I problem. For example, someone with severe mental retardation or a paranoid personality disorder may be more likely to be "bowled over" by a major life stressor, and succumb to a major depressive episode.

1.3.5.7 Axis-III

This value set represents problems associated with Axis III in DSM-IV.

Axis III lists any medical or neurological problems that may be relevant to the individual's current or past psychiatric problems; for example, someone with severe asthma may experience respiratory symptoms that are easily confused with a panic attack, or indeed, which may precipitate a panic attack.

NOTE: in this model Axis-III diagnoses are represented by the physicalProblem element in the ProblemsDiagnoses domain of the summary behavioral health document.

1.3.5.8 Axis-IV

Axis IV identifies the major recent psychosocial stressors the individual has faced recently; e.g., divorce, death of a loved one, job loss, etc.

1.3.5.9 Axis-V

This value set is associated with the score from the Global Assessment of Functioning (GAF).

Axis V codes the "level of function" the individual has attained at the time of assessment, and, in some cases, is used to indicate the highest level of function in the past year. This is coded on a 0-100 scale, with 100 being nearly "perfect" functioning.

1.3.5.10 BHAssessmentSectionType

The BHAssessmentSectionType value set contains the codes that correspond to a section of a Behavioral Health assessment. Each assessment section will be encoded as LOINC for interoperability.

During the next phase of this project, the terminology mapping process will produce a proposed starter value set enumerating a core list of assessments. The mapping process will result in a gap analysis which likely will lead to New Term Request and/or Change to Existing Term proposals for LOINC.

Data Element	Definition
CognitiveImpairmentScale	Cognitive Impairment Scale is the first section of GAIN
SubstanceFrequencyScale	Substance Frequency Scale is a section of GAIN
CurrentWithdrawalScale	Current Withdrawal Scale is a section of GAIN
TreatmentResistanceIndex	Treatment Resistance Index is a section of GAIN
TreatmentMotivationIndex	Treatment Motivation Index
Self-EfficacyScale	Self-Efficacy Scale
ProblemOrientationScale	Problem Orientation Scale
SubstanceProblemScale—Lifetime	Substance Problem Scale—Lifetime
HealthDistressScale	Health Distress Scale
Health Problem Scale	Health Problem Scale
Internal Mental Distress Scale	Internal Mental Distress Scale
Traumatic Stress Scale	Traumatic Stress Scale - subscale of the Internal Mental Distress Scale.
Behavior Complexity Scale	Behavior Complexity Scale
Emotional Problem Scale	Emotional Problem Scale
Environmental Risk Scale	Environmental Risk Scale

Data Element	Definition
General Conflict Tactic Scale	General Conflict Tactic Scale - subscale of the Crime and Violence Scale.
General Victimization Scale	General Victimization Scale
Personal Sources of Stress Index	Personal Sources of Stress Index
General Social Support Index	General Social Support Index
Illegal Activities Scale	Illegal Activities Scale
Employment Activity Scale	Employment Activity Scale
Training (School) Activity Scale	Training (School) Activity Scale
Recovery Environment Risk Index	Recovery Environment Risk Index

1.3.5.11 BHAssessmentType

The BHAssessmentType value set contains a list of candidate Behavioral Health assessment instruments used to assess clients.

LOINC is the recommended standard code system for Assessments Instruments, Assessment sections and the questions contained within each LOINC Assessment Instrument.

Every authority is free to use which ever instrument they choose, but each unique assessment instrument should be added to LOINC if it does not already exist.

Note: This value set is used to represent Axis-V assessments (e.g. CGAS, GAF) under the DSM IV TR code system as they are generally documented as assessment scores.

Data Element	Definition
ACE	Adverse Childhood Experience(ACE) The ACE Score attributes one point for each category of exposure to child abuse and/or neglect. Add up the points for a Score of 0 to 10. The higher the score, the greater the exposure, and therefore the greater the risk of negative consequences.

Data Element	Definition
ANSA	Assessment, Adult Needs and Strengths Assessment (ANSA) Source: The Praed Foundation http://www.praedfoundation.org/About%20the%20ANSA.html
AUDIT	Alcohol Use Disorders Identification Test: to detect alcohol problems experienced in the last year
AUDIT-C	3-Question screening; modified version of 10 question AUDIT
BDI–II	Beck Depression Inventory Author(s): Aaron T. Beck, Robert A. Steer, Gregory K. Brown
BPRS18	BPRS-18: Brief Psychiatric Rating Scale
CAGE	The CAGE can identify alcohol problems over the lifetime. Two positive responses are considered a positive test and indicate further assessment is warranted.
CANS	Child and Adolescent Need and Strengths (CANS) Source: The Praed Foundation www.praedfoundation.org
CAPS	Clinician-Administered PTSD Scale (CAPS) Source: Department of Veterans Affairs National Center for PTSD The CAPS is the gold standard in PTSD assessment. The CAPS is a 30-item structured interview that corresponds to the DSM-IV criteria for PTSD. The CAPS can be used to make a current (past month) or lifetime diagnosis of PTSD or to assess symptoms over the past week. In addition to assessing the 17 PTSD symptoms, questions target the impact of symptoms on social and occupational functioning, improvement in symptoms since a previous CAPS administration, overall response validity, overall PTSD severity, and frequency and intensity of five associated symptoms (guilt over acts, survivor guilt, gaps in awareness, depersonalization, and de realization). For each item, standardized questions and probes are provided. As part of the trauma assessment (Criterion A), the Life Events Checklist (LEC) is used to identify traumatic stressors experienced. CAPS items are asked in reference to up to three traumatic stressors. The CAPS was designed to be administered by clinicians and clinical researchers who have a working knowledge of PTSD, but can also be administered by appropriately trained paraprofessionals. The full interview takes 45-60 minutes to administer, but it is not necessary to administer all parts (e.g., associated symptoms).
CASII	This code identifies the "Child and Adolescent Service Intensity Instrument". The CASII applies to children ages 6 thru 17, measuring objective quantifiable criteria for determination of service intensity. It describes an array of services and a level of service intensity rather than a specific treatment setting or program. It does not describe a recommended level of care. The CASII is required as part of the initial 45 day assessment period, at a minimum of every 6 months thereafter, and at time of Episode of Care End from Behavioral Health services.

Data Element	Definition
CD-RISC	Connor-Davidson Resilience Scale (CD-RISC) (Besides the full 25-item CD-RISC (or CD-RISC 25), there are two briefer versions, the 10 item (CD-RISC 10) and two item (CD-RISC 2) scales.)
CGAS	Axis V identifies the patient's level of function on a scale of 0-100, (100 is top-level functioning). This is known as the Global The clinician's judgment of the client's overall level of functioning within the past 30 days, as indicated on the Global Assessment of Functioning (GAF) Scale for clients 18 & older or on the Children's Global Assessment Scale (CGAS) for clients 0 thru 17 Assessment of Functioning (GAF) Scale.
GAIN	This code identifies the "Global Appraisal of Individual Needs assessment instrument".
GAF	Axis V identifies the patient's level of function on a scale of 0-100, (100 is top-level functioning). This is known as the Global The clinician's judgment of the client's overall level of functioning within the past 30 days, as indicated on the Global Assessment of Functioning (GAF) Scale for clients 18 & older or on the Children's Global Assessment Scale (CGAS) for clients 0 thru 17 Assessment of Functioning (GAF) Scale.
DAST	Drug Abuse Screening Test; modified version of 10 question (DAST10)
DAST10	Drug Abuse Screening Test
GAD2	First 2 items of GAD-7. Ultra-brief anxiety screener.
GAD7	General Anxiety Disorder Screener - 7 Questions Anxiety measure developed after PHQ but incorporated into PHQ-SADS.
GAF Scale (AXIS-V)	DSM-IV Axis V identifies the patient's level of function on a scale of 0-100, (100 is top-level functioning). This is known as the Global The clinician's judgment of the client's overall level of functioning within the past 30 days, as indicated on the Global Assessment of Functioning (GAF) Scale for clients 18 & older.
GAS Scale (AXIS-V)	DSM-IV Axis V identifies the patient's level of function on a scale of 0-100, (100 is top-level functioning). This is known as the Global The clinician's judgment of the client's overall level of functioning within the past 30 days, as indicated on the Children's Global Assessment Scale (CGAS) for clients 0 thru 17. Assessment of Functioning (GAF) Scale.
GDS	Geriatric Depression Scale (GDS)
HAMD	Hamilton Depression Rating Scale
M3	M3 Screen
MADRS	Montgomery-Asberg Depression Rating Scale
MSE	**Mental Status Exam** **Recommendation:** Code System: LOINC [2.16.840.1.113883.6.1] LOINC: 10190-7 Mental status Narrative

Data Element	Definition
	Alternative code system: Values may be drawn from Code System: ICF [2.16.840.1.113883.6.254] (International Classification of Functioning, Disability, and Health (ICF)) http://www.who.int/classifications/icf/en/)
MMPI	Minnesota Multiphasic Personality Inventory®-2 (MMPI®-2) This is a proprietary assessment so the questions/responses will not be encoded in LOINC; only the Assessment name, MMPI.
MMSE	Mini-Mental Status Exam
PCL	PTSD Checklist (PCL) Source: Department of Veterans Affairs National Center for PTSD The PCL is a 17-item self-report measure of the 17 DSM-IV symptoms of PTSD. The PCL has a variety of purposes, including: • Screening individuals for PTSD • Diagnosing PTSD • Monitoring symptom change during and after treatment There are three versions of the PCL: 1. The PCL-M (military) asks about symptoms in response to "stressful military experiences." It is often used with active service members and Veterans. 2. The PCL-C (civilian) asks about symptoms in relation to "stressful experiences." The PCL-C is useful because it can be used with any population. The symptoms endorsed may not be specific to just one event, which can be helpful when assessing survivors who have symptoms due to multiple events. Typically, it is optimal to assess traumatic event exposure to ensure that a respondent has experienced at least one Criterion A event. 3. The PCL-S (specific) asks about symptoms in relation to an identified "stressful experience." The PCL-S is useful because the symptoms endorsed are clearly linked to a specified event. Typically, it is optimal to assess traumatic event exposure to ensure that the event meets Criterion A. Respondents also may be instructed to complete the PCL-S in reference to a specific type of event.
PC-PTSD	Primary Care PTSD Screen (PC-PTSD) Source: Department of Veterans Affairs National Center for PTSD The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.
BriefPHQ9	PHQ-9 and panic measures from original PHQ plus items on stressors and women's health. See scoring for PHQ above. Stressor and women's health items are not diagnostic or scored.

Data Element	Definition
PHQ	Five modules covering 5 common types of mental disorders: depression, anxiety, somatoform, alcohol, and eating. Selected (but provisional) DSM-IV diagnoses for all types of disorders except somatoform.
PHQ2	First 2 items of PHQ-9. Ultra-brief depression screener. Two items scored 0 to 3 (total score of 0-6)
PHQ4	Patient Health Questionnaire - 4 Questions
PHQ8	All items of PHQ-9 except the 9th item on self-harm. Mainly used in non-depression research studies. Eight items, each of which is scored 0 to 3, providing a 0 to 24 severity score.
PHQ9	Depression scale from PHQ. Nine items, each of which is scored 0 to 3, providing a 0 to 27 severity score.
PHQ15	Somatic symptom scale from PHQ. Fifteen items, each of which is scored 0 to 2, providing a 0 to 30 severity score.
PHQA	Substantially modified version of PHQ developed for use in adolescents. Moderate data exists for validity but much less than for original PHQ. Diagnostic scoring described in manual, available upon request.
BAI-PC	Beck Anxiety Inventory - Primary Care (BAI-PC) Source: Department of Veterans Affairs National Center for PTSD The BAI-PC is a 7-item self-report that screens for anxiety, depression and Post Traumatic Stress Disorder (PTSD), a subset of the original 21-item Beck Anxiety Inventory. The main benefit to the use of this screen is that it simultaneously screens for PTSD as well as other disorders that are highly co-morbid with PTSD. Respondents are asked to rate items on a 4-point scale (ranging from 0 = "Not at all" to 3 = "Severely") to indicate the severity of each of the symptoms. The authors use a total score of 5 to indicate a positive screen for anxiety, depression or PTSD.
PHQ-SADS	PHQ-9, GAD-7, and PHQ-15 measures, plus panic measure from original PHQ. See scoring for these scales above
SF-PTSDCivilian	Short Form of the PTSD Checklist - Civilian Version Source: Department of Veterans Affairs National Center for PTSD This 6-item screen was derived empirically from the PCL-C (Weathers et al., 1994) for use in primary care settings. It contains the 2 items from each of the re-experiencing, avoidance, and hyper-arousal clusters that correlated most highly with the individual cluster score on the PCL-C. Respondents rate items on a 5-point scale (ranging from 1 = "Not at all" to 5 = "Extremely"). The authors suggest a cutoff score of 14. Those screening positive should then be assessed with a structured interview for PTSD.
SPAN	Startle, Physically upset by reminders, Anger, and Numbness Source: Department of Veterans Affairs National Center for PTSD The SPAN is a 4-item self-report screen derived from the Davidson Trauma Scale.

Data Element	Definition
	Its name is an acronym for the 4 symptoms assessed (startle, physically upset by reminders, anger, and numbness). The 4 items that make up the SPAN are the items from the DTS that best distinguished a sample of patients with PTSD from a sample of patients without PTSD. Respondents are asked to rate items on a 5-point scale (ranging from 0 = "Not at all distressing" to 4 = "Extremely distressing") to indicate how distressing each of the symptoms-items has been during the past week. A total score of 5 indicates a positive screen. Those screening positive should then be assessed with a structured interview for PTSD.
SPRINT	Short Post-Traumatic Stress Disorder Rating Interview Source: Department of Veterans Affairs National Center for PTSD The Short Post-Traumatic Stress Disorder Rating Interview (SPRINT; Connor and Davidson, 2001) is an 8-item self-report measure that assesses the core symptoms of PTSD (intrusion, avoidance, numbing, arousal), somatic malaise, stress vulnerability, and role and social functional impairment. Symptoms are rates on 5 point scales from 0 (not at all) to 4 (very much). The SPRINT was responsive to symptom change over time and correlated with comparable PTSD symptom measures. The SPRINT demonstrates solid psychometric properties and can serve as a reliable, valid, and homogeneous measure of PTSD illness severity and of global improvement. The authors suggest a cut-off score of 14 for this screen. Those screening positive should then be assessed with a structured interview for PTSD.
SBIRT	Screening, Brief Intervention, and Referral to Treatment SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. • Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. • Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. • Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.
SSS-PTSD	Short Screening Scale for PTSD Source: Department of Veterans Affairs National Center for PTSD The Short Screening Scale for PTSD is a 7-item screen that was designed for all trauma survivors. The screen was empirically derived in the context of an epidemiological study of PTSD in an urban area of the United States. The 7 items were those that most efficiently predicted PTSD diagnostic status. The screen was designed to be administered after an assessment of trauma exposure. It consists of 5 avoidance items and 2 hyper-arousal items. Respondents rate each item as either "yes" or "no" and the screen is scored by adding the number of "yes" responses. The authors suggest a cutoff score of 4 for this screen. Those screening positive should then be assessed with a structured interview for PTSD.
TSQ	Trauma Screening Questionnaire (TSQ) Source: Department of Veterans Affairs National Center for PTSD

Data Element	Definition
	The TSQ is a 10-item symptom screen that was designed for use with survivors of all types of traumatic stress. The TSQ is based on items from the PTSD Symptom Scale - Self Report (PSS-SR; Foa et al., 1993) and has 5 re-experiencing items and 5 arousal items. Respondents are asked to endorse those items that they have experienced at least twice in the past week. Brewin et al. (2002) considered the screen "positive" when at least 6 items were endorsed. The authors recommended that screening be conducted 3-4 weeks post-trauma to allow for normal recovery processes to take place. Those screening positive should then be assessed with a structured interview for PTSD.

1.3.5.12 BehavioralHealthCategory

This example value set identifies the behavioral health category used to classify clients on the basis of age, diagnosis and, when applicable, functional status. This is an optional, state-specific element and is rules-based using various client characteristics such as client's age, functional impairment category, and problems.

This classification is an optional element that is state-specific. In future work, this element will be represented as a data structure.

In order to be placed into a specific category, the client must have one of the qualifying diagnoses and functional impairment for that age group (e.g. under 18 of age, 18 years and older). It is used to identify clients that may be eligible for integrated services coordination.

This starter value set includes five possible designations (i.e., child non-SED, child with SED, adult with SMI, adult non-SMI with general mental health need and adult non-SMI with substance abuse) which are assigned to each client enrolled in the state behavioral health system.

The problems that identify Severe Emotional Disturbed and Severely Mentally Ill are drawn from the Severe Emotionally Disturbed and Severely Mentally Ill value sets.

Data Element	Definition
Child	Child Only valid for ages 17 and under
Child SED	Child, Seriously Emotionally Disturbed (SED) Only valid for ages 17 and under
AdultSMI	Adult, with serious mental illness Only valid for ages 18 and older
AdultMH	Adult, non-seriously mentally ill, with general mental health need Only valid for ages 18 and older

Data Element	Definition
AdultSA	Adult, non-seriously mentally ill, Substance abuse, either alcohol or drug Adult, with serious mental illness

1.3.5.13 ClientRating

The ClientRating value set is used to describe a client's response to questions related to their willingness to participate in treatment programs, level of concern about particular problems, etc. It is intended to represent a scale from 1 to 5, for example, Not at all to extremely.

Data Element	Definition
notAtAll	Not at all
slightly	Slightly
moderately	Moderately
considerably	Considerably
extremely	Extremely

1.3.5.14 Confidentiality

The Confidentiality value set is used to describe the sender's sensitivity classification of the information contained within the document intended for exchange. This classification is based on an analysis of applicable privacy policies and the risk of harm that could result from unauthorized disclosure.

Confidentiality codes are used as metadata indicating the receiver responsibilities to ensure that the information is not made available or re-disclosed to unauthorized individuals, entities, or processes (security principals) per applicable policies.

Data Element	Definition
Normal	Privacy metadata indicating that the information is typical, non-stigmatizing health information, which presents typical risk of harm if disclosed without authorization. **N**
Restricted	Privacy metadata indicating highly sensitive, potentially stigmatizing information, which presents a high risk to the information subject if disclosed without authorization. May be preempted by jurisdictional law, e.g., for public health reporting or emergency treatment. Restricted is the default confidentiality code for behavioral health information in document exchange. **R**
Very Restricted	Privacy metadata indicating very restricted access as declared by the Privacy Officer of the record holder. **V**

1.3.5.15 CriminalJusticeComplianceStatus

This value set is used to represent the client / patient's attendance or measurable compliance with criminal justice system (parole or pre-trial events). This information is intended to come from case worker / criminal justice system.

Data Element	Definition
compliantWithCourtSchedule	Compliant with court schedules
notCompliantWithCourtSchedule	Not compliant with court schedules
compliantWithPreTrialEvents	Compliant with pre-trial events
notCompliantWithPreTrialEvents	Not compliant with pre-trial events
compliant with terms of parole	Compliant with terms of parole
notCompliantWithTermsOfParole	Not compliant with terms of parole

1.3.5.16 CriminalJusticeSystemInvolvementStatus

This value set specifies the correctional system status (incarcerated, on parole, on probation) of clients who were adjudicated guilty.

This value set specifies the correctional system status (incarcerated, on parole, on probation) for clients who have been adjudicated guilty at the time they have entered treatment. In order to fully determine the correctional system involvement for a client, the correctional system status and correctional system type must be known because the age of a client cannot be used to determine which type of correctional system in which a client is placed, (adult versus juvenile system).

The starter value sets for the CriminalJusticeSystemStatus and CriminalJusticeSystemType can be used to derive the client's involvement in the correctional system when applicable, e.g. Adult Parole / Juvenile Parole, Adult Incarceration / Juvenile Incarceration, etc.

Data Element	Definition
Parole	The client is on parole. Parole is the early release of an inmate who has served part of his or her prison sentence. The inmate is allowed to return to the community under the conditions of parole and the supervision of a parole agent. Violation of these conditions can result in a revocation of the parole and re-imprisonment for

Data Element	Definition
	the offender.
Probation	The client is on probation. Probation is a decision handed down by the judge at trial. It may be in lieu of jail time or in combination with some jail time. It allows the convicted person to live in the community for a specified period of time under the supervision of a probation officer. Depending on the circumstances and the seriousness of the crime, the judge can specify restrictions on the offender's activities during the probationary period. If an offender violates the conditions or rules of probation, he or she may be sentenced to imprisonment by the judge. This is known as revoking the probation or revocation.
Incarceration	The client confined in a jail or prison; imprisoned. This code is used if client is in the custody of the department of corrections.

1.3.5.17 CriminalJusticeSystemInteractionType

This value set is used to express any interaction that a client may have had with the criminal justice system.

Data Element	Definition
NoArrests	Individual has no known arrests in the past.
ArrestNotPast30Days	Individual has history of arrests, but no arrests past 30 days
OneOrTwoPast30Days	Individual has 1 to 2 arrests in last 30 days.
GreaterThanTwoArrests Past30Days	Individual has more than 2 arrests in last 30 days.

1.3.5.18 CriminalJusticeSystemType

This value set specifies the type of correctional system under which the client has been adjudicated guilty at the time they entered treatment (adult versus juvenile).

In order to fully determine the correctional system involvement for a client, the correctional system status and correctional system type must be known because the age of a client cannot be used to determine which type of correctional system in which a client is placed (adult versus juvenile system). The starter value sets for the CriminalJusticeSystemInvolvementStatus CorrectionalSystemInvolvementStatus and CorrectionalSystemType can be used to derive the client's involvement in the correctional system when applicable, e.g. Adult Parole / Juvenile Parole, Adult Incarceration / Juvenile Incarceration, etc.

Data Element	Definition

Data Element	Definition
Adult	This is a qualifier to distinguish that the client has been adjudicated under an Adult correctional system.
Juvenile	This is a qualifier to distinguish that the client has been adjudicated under a Juvenile correctional system.

1.3.5.19 DomesticViolenceTrauma

This value set is used to represent client's experience with aspects of violence, domestic and/or trauma. The example values were gleaned from the CSAT GPRA Client Outcome Measures for Discretionary Programs Codebook as well as HMIS field 4.9 Domestic Violence.

Data Element	Definition
anyViolence	Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief?)
nightmares	Have had nightmares about it or thought about it when you did not want to?
triedHardToForget	Tried hard not to think about it or went out of your way to avoid situations that remind you of it?
constantGuard	Were constantly on guard, watchful, or easily startled?
numbDetached	Felt numb and detached from others, activities, or your surroundings?
physicallyHurt	Been hit, kicked, slapped, or otherwise physically hurt?

1.3.5.20 EducationalAccommodationProgram

This value set is used to specify the type educational program that the client may be enrolled in and receiving services. It refers to other agencies with a current and/or ongoing role with the Individualized Education Program (IEP) or accommodations through a 504 Accommodation Plan at his/her school.

Data Element	Definition
504AccommodationPlan IEP	This code indicates that the client is enrolled and participated in a generic education program under called an Individualized Education Program related to Section 504 of the Rehabilitation Act and with the Americans with Disabilities Act (ADA).
SpecialEducation	This code indicates that the client is enrolled and participated in a special education program.
Vocational	This code indicates that the client is enrolled and participated in a vocational education program.
SecondaryEducation	This code indicates that the client is enrolled and participated in a generic secondary education program.

1.3.5.21 EducationalBehavior

This value set is used to represent the client's educational behavioral issues.

Data Element	Definition
Classroom disruption	Client has a propensity to interfere with the classroom experience of others.
Aggression	Client has a propensity to damage classroom objects, hurt and or bully others.
Isolation	Client avoids contact with others.
Victimization	Client has a propensity for being bullied.

1.3.5.22 EmploymentStatus

This value set includes allowable values for the employment status of a client.

Data Element	Definition
Unemployed	Not currently employed, but looking for work in the past 30 days or on layoff from a job.
Volunteer	If an individual volunteers (unpaid) their time in the community on a regular basis, and does not fit the criteria for Employed, Transitional Employment, or Work Adjustment Training, they shall be categorized as 14-Volunteer.
Unpaid Rehabilitation Activity	This may include individuals engaging in any rehabilitation activity not already specified in one of the other categories, such as: work exploration, pre-vocational skill building groups and activities, community activities such as church groups, social skill building activities, mobility training, adjustment to disability training, etc.
Homemaker	If an individual manages their family household as a principal occupation, and performs household duties for others, they shall be categorized as Homemaker.
Student	If an individual is currently in school and not involved in any other work activity, they shall be categorized as “student”. If an individual is in school, but also competitively employed or involved in Transitional Employment or Work Adjustment Training, they shall be categorized in the appropriate employment category.
Retired	If an individual has concluded their working or professional career, and does not fit the criteria for Student or Volunteer, they shall be categorized as Retired.
Disabled	Not currently employed or looking for work. Not involved in any other rehabilitation activity. Use this category only if the individual does not fit in any other category.
Inmate of Institution	When an individual resides in a jail or correctional facility with care provided 24 hours, 7 days a week basis. This includes the state hospital, jail, correctional facility, prison, youth authority facility, juvenile hall, boot camp or Boys Ranch.
Competitively Employed Full Time	Refers to work performed in an integrated community setting on a full time basis (35 or more hours per week) for which an individual is compensated in accordance with the Fair Labor Standards Act; or client is in military service. Criteria for competitive employment must include the following three components: pay at minimum wage or higher, a job located in a mainstream integrated setting, and a job that was not set aside for mental health clients. This category may also include individuals who are employed as Peer Support Specialists / Recovery Support Specialists. Employment may be with or without interventions, assistance or supports typically provided by staff of a vocational or other rehabilitation program.

Data Element	Definition
	The individual may have obtained the job with the assistance of a vocational program or on their own.
Competitively Employed Part Time	Refers to work performed in an integrated community setting on a part time basis (less than 35 hours per week) for which an individual is compensated in accordance with the Fair Labor Standards Act; or client is in military service. Criteria for competitive employment must include the following three components: pay at minimum wage or higher, a job located in a mainstream integrated setting, and a job that was not set aside for mental health clients. This category may also include individuals who are employed as Peer Support Specialists / Recovery Support Specialists. Employment may be with or without interventions, assistance or supports typically provided by staff of a vocational or other rehabilitation program. The individual may have obtained the job with the assistance of a vocational program or on their own.
Work Adjustment Training	Facility or community based paid training program that teaches the meaning, value and demands of work. Individuals perform paid work activities and are accompanied by a job coach. These paid work activities are geared towards assisting the individual in gaining work experience and developing the soft skills needed to obtain competitive employment. Participation in work adjustment training programs should preferably be time-limited, with a long term goal of obtaining competitive employment. Participation in a work adjustment training program is set aside for mental health clients and/or other participants of a rehabilitation program.
Transitional Employment Placement	Temporary employment placements secured by a vocational agency (such as a Fountain House model clubhouse program) and set aside for mental health clients. Employment is paid and is in an integrated / mainstream business setting. Individuals are actual employees of the company, not of the clubhouse. Individuals are paid at least minimum wage, and preferably the prevailing rate received by regular company employees for the same job. Placement work is done in the company's place of business, never in the clubhouse.

1.3.5.23 EpisodeOfCareCompletion

This value set denotes how an episode of care ended. The completion code is recorded when the episode of care ends. This uses the EpisodeOfCareCompletion value set.

Data Element	Definition
Treatment completed	This code indicates that the episode of care ended because the treatment was completed.
Change in eligibility	This code indicates that the episode of care ended because the client's eligibility changed.
Client declined further service	This code indicates that the episode of care ended because the client declined further treatment.
Lack of contact	This code indicates that the episode of care ended because the client has not contacted the provider organization.
Incarceration	This code indicates that the episode of care ended because the client was detained/incarcerated.
Death of client	This code indicates that the episode of care ended because the client is deceased. This may map to a number of valid values within the National Uniform Billing Council (NUBC UB-04) standard billing codes which capture death at a more granular level.

Data Element	Definition
Moved out of area	This code indicates that the episode of care ended because the client moved out of the area.
Transfer	This code indicates that the episode of care ended because the client was transferred into the care of another provider organization. Transfer maps to a number of more granular Transfer of service codes within the standard UB-04 Code System.
Crisis end – referred for treatment	This code indicates that the episode of care ended because the specific crisis ended and the client was referred for care.
Failed to complete treatment	This value represents the close of an episode of care due to the fact that the client was unable to complete the treatment plan.
Failed to comply with treatment plan	This value indicates the reason for end of episode is due to the client not complying with the treatment plan.

1.3.5.24 EpisodeOfCareType

This value set is used to reflect the type of encounter that triggers the submission of a Behavioral Health Report. It is used to distinguish between encounters that take place during Crisis episodes and routine Behavioral Health episodes.

This information, along with the value associated with the episodeOfCareStatus data element; represents the information that was previously conveyed using the SubmissionTrigger. E.g., New Episode Start/Crisis, New Episode Start/Behavioral Health Episode, End Episode/Crisis, etc.

Data Element	Definition
CrisisEncounter	This value denotes this report as pertaining to a Crisis encounter. SNOMED-CT: 4525004 (emergency department patient visit) [procedure] SNOMED-CT: 4525004 (emergency department patient visit) [procedure]
RoutineBHEncounter	This value describes a routine Behavioral Health client encounter is the reason for Behavioral Health Report submission, used to distinguish from a Crisis encounter. Many values under the SNOMED-CT hierarchy: 14736009 (patient evaluation and management) [procedure] can be used to describe "routine" encounters. There may be GAPS under this hierarchy for Behavioral Health.

1.3.5.25 FormalEducationLevel

This value set refers to the highest level of formal (school) education completed by the client to date.

Data Element	Definition

Data Element	Definition
Age 0-4 - none	
Grades K-3	
Grades 4-6	
Grades 7-8	
Grades 9-12	
High-school Graduate	
Vocational/Technical	
Some College	
Associates/Bachelor Degree	
Graduate/Post-Graduate Degree	

1.3.5.26 GenderSelfIdentity

This value set is used to specify the client's gender identity, otherwise known as core gender identity, and indicates how the client self-identifies. It is not necessarily based on the person's anatomy.

Data Element	Definition
Gender Variant	Gender Variant: a person who self-identifies as both man and woman OR as neither man nor woman.
Man	Man: a person who self-identifies as a man.
Intersex	Intersex: a person who self-identifies as Intersex, which is defined as "born with a set of recognized medical conditions that may make sex difficult to determine".
Questioning	Questioning: a person who is questioning his or her gender identity.
Transgender	Transgender: a person who lives or self-identifies as a member of a gender other than that expected based on anatomical sex
Woman	Woman: a person who self-identifies as a woman.
Decline to Answer	Decline to Answer: a person who did not answer the question; or a person who declined to answer the question

Data Element	Definition
Not Applicable	Not Applicable Due to Age: Ages 0 thru 17.

1.3.5.27 HousingAtHomelessProgramDischarge

This value set describes where a client / patient will be staying after they leave the Homeless program.

Data Element	Definition
emergencyShelter	Emergency shelter, including hotel or motel paid for with emergency shelter voucher
transitionalHousing	Transitional housing for homeless persons (including homeless youth)
permanentSupportiveHousing	Permanent supportive housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)
psychiatricFacility	Psychiatric hospital or other psychiatric facility
substanceAbuseTreatmentFacility	Substance abuse treatment facility or detox center
skilledNursingFacility (SNF)	Long-term care facility or nursing home
halfwayHouse	Residential provider program or halfway house with no homeless criteria
jailPrison	Jail, prison or juvenile detention facility
clientRentalNoSubsidy	Rental by client, no ongoing housing subsidy
clientOwnedHomeNoSubsidy	Owned by client, no ongoing housing subsidy
temporaryResidenceFamily	Staying or living with family, temporary tenure (e.g., room, apartment or house)
temporaryResidenceFriends	Staying or living with friends, temporary tenure (.e.g., room apartment or house)
fosterCare	Foster care home or foster care group home
placeNotMeantForHabitation	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
safeHaven	Safe Haven

Data Element	Definition
rentalVASHSubsidy	Rental by client, VASH Subsidy
rentalNonVASHSubsidy	Rental by client, other (non-VASH) ongoing housing subsidy
clientOwnedWithSubsidy	Owned by client, with ongoing housing subsidy:
withFamilyPermanent	Staying or living with family, permanent tenure
withFriendsPermanent	Staying or living with friends, permanent tenure
unknownResidence	Client doesn't know
deceased	Client is deceased

1.3.5.28 HousingStatus

This value set is used to identify persons who, at program entry and program exit, are literally homeless; housed, but at imminent risk of losing their housing; housed, but at-risk of losing their housing; or in a stable housing situation.

Data Element	Definition
Literally Homeless	• Places not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground • A supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing for homeless persons) • A hospital or other institution, if the person was sleeping in an emergency shelter or other place not meant for human habitation (cars, parks, streets, etc.) immediately prior to entry into the hospital or institution • Fleeing a domestic violence situation
Imminently losing their housing	• Places not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground • A supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing for homeless persons) • A hospital or other institution, if the person was sleeping in an emergency shelter or other place not meant for human habitation (cars, parks, streets, etc.) immediately prior to entry into the hospital or institution • Fleeing a domestic violence situation

1.3.5.29 ImmunizationCode

This value set is intended to contain the list of codes used to represent an immunization.

The recommended ImmunizationCode value set is developed and maintained by the CDC's National Center of Immunization and Respiratory Diseases (NCIRD).

1.3.5.30 IncomeSource

This value set is used to represent the source of a client's income within the past 30 days. These values were drawn from "Final HMIS Data Standards March 2010" (Homeless Management Information System) associated with field 4.1 Income and Sources.

See: https://www.onecpd.info/resources/documents/FinalHMISDataStandards_March2010.pdf

Data Element	Definition
earnedIncome	Earned Income (i.e., employment income)
unemploymentInsurance	Unemployment Insurance
supplementalSecurityIncome	Supplemental Security Income (SSI)
socialSecurityDisabilityIncome	Social Security Disability Income (SSDI)
disabilityPaymentVA	Veteran's disability payment
disabilityInsurance	Private disability insurance
workersComp	Worker's compensation
temporaryAssistanceNeedyFamilies	Temporary Assistance for Needy Families (TANF) (or local program name)
generalAssistance	General Assistance (GA) (or local program name)
retirementIncomeSSI	Retirement income from Social Security
pensionVA	Veteran's pension
childSupport	Child support

Data Element	Definition
alimony	Alimony or other spousal support

1.3.5.31 LanguageAbilityMode

This value set is used to express the client's ability with the spoken language and uses the LanguageAbilityMode value set.

Data Element	Definition
Expressed signed	The client is able to sign.
Expressed spoken	The client is able to verbally express herself.
Expressed written	The client is able to express herself in writing.
Received signed	Received signed - needs definition
RSP (received spoken)	Received spoken - needs definition
RWR (received written)	Received written - needs definition

1.3.5.32 LanguageAbilityProficiency

This value set is used to express the client's proficiency with language and uses the LanguageAbilityProficiency value set.

Data Element	Definition
Excellent	Client's language proficiency is excellent.
Fair	Client's language proficiency is fair.
Poor	Client's language proficiency is poor.
Good	Client's language proficiency is good.

1.3.5.33 MaritalStatus

This value set represents marital statuses for a client.

Data Element	Definition
NeverMarried	Never Married
Married	Currently married.

Data Element	Definition
Annulled	Marriage annulled.
Divorced	Divorced
LegallySeparated	Legally separated from marriage.
DomesticPartner	Domestic partner.
Interlocutory	The initial judgment of divorce. When courts grant divorces, their judgments are not final until the expiration of a statutory waiting period known as the interlocutory or nisi period. It begins when the interlocutory judgment enters and ends upon the "final judgment of divorce," or "final decree." State law varies greatly in this regard, so check with your attorney. Despite your judgment of divorce nisi or interlocutory decree, you are still legally married and cannot remarry until the judgment becomes final.
Polygamous	The condition or practice of having more than one spouse at one time.
Widowed	A person whose spouse has died and they have not remarried.

1.3.5.34 MilitaryBranchOfService

This value set lists the branch of service within the United States Military in which the veteran is/was enrolled.

Data Element	Definition
Air Force	Air Force
Army	Army
Coast Guard	Coast Guard
Marines	Marines
Navy	Navy

1.3.5.35 MilitaryHistoryStatus

This value set contains the list of valid military history status within the United States Military.

Data Element	Definition
ActiveDuty	Active Duty

Data Element	Definition
Retired	Retired
Reserves	Reserves
Unknown	Unknown

1.3.5.36 MilitaryServiceDischargeStatus

This value set contains the various statuses that can be conferred on a veteran at the time of discharge.

Data Element	Definition
Bad Conduct	Bad conduct discharge
Dishonorable	Dishonorable discharge
General	General Conduct Discharge
Honorable	Honorable Discharge
Other than Honorable	Other than Honorable conduct discharge

1.3.5.37 MilitaryServiceEra

This value set is used to collect a more detailed profile of the homeless veteran's experience and to determine eligibility for Department of Veterans Affairs (VA) programs and benefits. These questions were developed in consultation with the VA and reflect the Department of Housing and Urban Development (HUD) efforts to standardize data definitions and standards across federal agencies.

These example values were taken from Final HMIS Data Standards March 2010 (Homeless Management Information System), field 4.15E Veteran's Information

See:
https://www.onecpd.info/resources/documents/FinalHMISDataStandards_March2010.pdf

Data Element	Definition
Persian Gulf Era	Persian Gulf Era (August 1991 - September 10, 2001)

Data Element	Definition
Post Vietnam	Post Vietnam (May 1975 - July 1991)
Vietnam Era	Vietnam Era (August 1964 - April 1975)
Between Korean and Vietnam War	Between Korean and Vietnam War (February 1955 - July 1964)
Korean War	Korean War (June 1950 - January 1955)
Between WWII and Korean War	Between WWII and Korean War (August 1947 - May 1950)
World War II	World War II (September 1940 - July 1947)
Post September 11, 2001 to Present	Post September 11, 2001 (September 11, 2001 - Present)

1.3.5.38 NonCashBenefit

This value set is used to represent the non-cash benefits a client may be receiving.

Data Element	Definition
SNAP	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)
MEDICAID	MEDICAID health insurance program (or use local name)
MEDICARE	MEDICARE health insurance program (or use local name)
SCHIP	State Children's Health Insurance Program (or use local name)
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
VA	Veteran's Administration (VA) Medical Services
TANF	TANF Child Care services (or use local name)
TANFTransport	TANF transportation services (or use local name)
OtherTANF	Other TANF-funded services (or use local name)
Section8	Section 8, public housing, or other ongoing rental assistance

Data Element	Definition
Temporary RentalAssistance	Temporary rental assistance

1.3.5.39 OMHDisabilityStatus

This value set is used to convey information related to the level of disability for a Behavioral Health client and reflects the questions presented in the Office of Minority Health (OMH) Data Standard for Disability Status.

See OMHDisabilityStatus for recommendation on standards-based encoding.

Data Element	Definition
CognitiveDisability	Question 3: Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions? (5 years old or older)
HearingDisability	Question 1: Are you deaf or do you have serious difficulty hearing?
OtherADLDisability	Question 6: Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)
PersonalCareDisability	Question 5: Do you have difficulty dressing or bathing? (5 years old or older)
VisualDisability	Question 2: Are you blind or do you have serious difficulty seeing, even when wearing glasses?
WalkingDisability	Question 4: Do you have serious difficulty walking or climbing stairs? (5 years old or older)

1.3.5.40 OMHEthnicity

The OMHEthnicityCodeValueSet value set reflects the categories of ethnicity used to describe a client as depicted by the questions in the Office of Minority Health ethnicity code standard. It is used to distinguish whether or not the client is Hispanic. A client may report more than one ethnicity.

Race and ethnicity are considered separate and distinct identities, with Hispanic or Latino origin asked as a separate question from race.

Data Element	Definition
HispanicLatino	This code is used to indicate a client who self-identifies as Hispanic or Latino client. This value maps to OMH Ethnicity data standard question (3) Yes, Another Hispanic, Latino, or Spanish Origin and rolls up to the Hispanic or Latino category of the OMB standard.
NotHispanicLatino	This code is used to indicate a client who does not identify as Hispanic or Latino. This value maps to OMH Ethnicity data standard question (a) No, not of Hispanic, Latino/a, or Spanish origin and rolls up to the Hispanic or Latino category of the OMB standard.

Data Element	Definition
Mexican American	This code is used to indicate a client who self-identifies as Mexican American. This value maps to OMH Ethnicity data standard question (b) Yes, Mexican, Mexican American, Chicano/a and rolls up to the Hispanic or Latino category of the OMB standard.
Puerto Rican	This value is used to indicate a client who self-identifies as Puerto Rican. This value maps to OMH Ethnicity data standard question (c) Yes, Puerto Rican and rolls up to the Hispanic or Latino category of the OMB standard.
Mexican	This value is used to indicate a client who self-identifies as Mexican. This value maps to OMH Ethnicity data standard question (b) Yes, Mexican, Mexican American, Chicano/a and rolls up to the Hispanic or Latino category of the OMB standard.
Chicano/a	This code is used to indicate a client who self-identifies as Chicano or Chicana. This value maps to OMH Ethnicity data standard question (b) Yes, Mexican, Mexican American, Chicano/a and rolls up to the Hispanic or Latino category of the OMB standard.
Cuban	This value is used to indicate a client who self-identifies as Cuban. This value maps to OMH Ethnicity data standard question (d) Yes, Cuban and rolls up to the Hispanic or Latino category of the OMB standard. This code is used to indicate a client who self-identifies as Cuban.

1.3.5.41 OMHRace

This value set contains the Office of Minority Health race codes used to describe the client. The client may report more than one race.

Race and ethnicity are considered separate and distinct identities, with Hispanic or Latino origin asked as a separate question.

The OMHRaceCodeValueSet value set includes all values defined in the Office of Minority Health (OMH) data standards for Race.

Data Element	Definition
American Indian or Alaska Native	This value is used to indicate a client having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. This value maps to OMH Race data standard question (c) American Indian or Alaska Native.
Asian	This value is used to indicate a client having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. This value maps to OMH Race data standard question (j) Other Asian in OMH Race codes.
Black	This value is used to indicate a client having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.” This value maps to OMH Race data standard question (b) Black of African American and is part of the current OMB standard.
NativeHawaiian	This value is used to indicate a native Hawaiian client and this value maps to OMH Race data standard question (k) Native Hawaiian. This value rolls up to the Native Hawaiian or Other Pacific Islander category of the OMB standard.
White	This value is used to indicate a client having origins in any of the original peoples of Europe, the Middle East or North Africa. This value maps to the OMH Race data standard question (a) and is part of the current OMB standard.

Data Element	Definition
AsianIndian	This value is used to indicate a client who self-identifies as an Asian Indian. This value maps to OMH Race data standard question (d) Asian Indian and rolls up to the Asian category of the OMB standard.
Chinese	This value is used to indicate a client who self-identifies as Chinese. This value maps to OMH Race data standard question (e) and rolls up to the Asian category of the OMB standard.
Filipino	This value is used to indicate a client who self-identifies as Filipino. This value maps to OMH Race data standard question (f) and rolls up to the Asian category of the OMB standard.
Japanese	This value is used to indicate a client who self-identifies as Japanese. This value maps to OMH Race data standard question (g) and rolls up to the Asian category of the OMB standard.
Korean	This value is used to indicate a client who self-identifies as Korean. This value maps to OMH Race data standard question (h) and rolls up to the Asian category of the OMB standard.
Vietnamese	This value is used to indicate a client who self-identifies as Vietnamese. This value maps to OMH Race data standard question (i) and rolls up to the Asian category of the OMB standard.
Native HawaiianOrOtherPacific Islander	This value is used to indicate a client having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. This value is included in the minimum race and ethnicity categories defined by the U.S. Office of Management and Budget (OMB).
GuamanianOrChamorro	This value is used to indicate a client who self-identifies as Guamanian or Chamorro. This value maps to OMH Race selection (l) and rolls up to the Native Hawaiian or Other Pacific Islander category of the OMB standard.
Samoan	This value is used to indicate a client who self-identifies as Samoan. This value maps to OMH Race selection (m) and rolls up to the Native Hawaiian or Other Pacific Islander category of the OMB standard.
OtherPacificIslander	This value is used to indicate a client who self-identifies as Other Pacific Islander. This value maps to OMH Race selection (n) and rolls up to the Native Hawaiian or Other Pacific Islander category of the OMB standard.
OtherRace	This value is included in the minimum race and ethnicity categories currently defined by the U.S. Office of Management and Budget (OMB)standard and is used by clients to self-identify as falling into category "Other" (i.e., not one of the five general categories (White, Black/African American, Native Hawaiian or Other Pacific Islander, Asian or American Indian/Alaska Native).

1.3.5.42 PeerGroupType

This value set represents the type of peer group that a client may attend during the course of treatment.

Data Element	Definition
VetSAPeerGroup	Veterans-focused Substance Abuse-Oriented Peer Group
VetMHPeerGroup	Veterans-focused Mental Health-Oriented Peer Group

Data Element	Definition
VetPhysCondPeerGroup	Veterans-focused Physical Condition-Oriented Peer Group
YouthSAPeerGroup	Youth-focused Substance Abuse-Oriented Peer Group
OffenderSAPeerGroup	Offender-focused Substance Abuse-Oriented Peer Group
FaithBasedSAPeerGroup	Faith-based Substance Abuse-Oriented Peer Group
FaithBasedMHPeerGroup	Faith-based Mental Health-Oriented Peer Group
FailthBasedPhysCondPeerGroup	Faith-based Physical Condition-Oriented Peer Group
YouthMHPeerGroup	Youth-focused Mental Health-Oriented Peer Group
YouthPhyscCondPeerGroup	Youth-focused Physical Condition-Oriented Peer Group
OffenderMHPeerGroup	Offender-focused Mental Health-Oriented Peer Group
OffenderPhysCondPeerGroup	Offender-focused Physical Condition-Oriented Peer Group

1.3.5.43 PreferredLanguage

This value set contains the standards-based language codes used to represent the preferred (or secondary) language that a client prefers to use for communication.

It uses the three-character codes found in the PreferredLanguage (ISO 639-2) constrained to values found in the ISO 639-1 code system (only active languages) as ISO 639-2 includes languages no longer in use.

1.3.5.44 PregnancyPuerperium

This value set is used to describe the pregnancy or post-partum status of female clients in treatment.

Data Element	Definition
Patient currently pregnant	Client is currently pregnant.
Postpartum finding	Client is post-partum.

1.3.5.45 PrimaryResidence

The PrimaryResidence value set is used to specify the place where the client has spent most of his/her time in the past 30 days prior to intake or any change thereafter.

Data Element	Definition
IndependentLiving	Independent living: Client lives in a private residence with or without support in activities of daily living. Living arrangement may be with a roommate, housemate, and spouse or by self. Use only with individuals 15 years or older.
BoardingHome	Boarding Home: An unlicensed residence that provides no behavioral health services but includes room and board.
SupervisoryCareAssisted living	Supervisory care/assisted living: A facility licensed by state Assisted Living licensure. Use only with individuals 18 years or older.
State Hospital	A publicly funded inpatient facility for clients with mental illness. Use only with individuals 18 years or older.
Jail/Correctional facility	When an individual resides in a jail and/or correctional facility with care provided 24 hours, 7 days a week basis. This includes jail, correctional facility, prison, youth authority facility, juvenile hall, boot camp or Boys Ranch.
HomelessHomelessShelter	Homeless/homeless shelter: A client is considered homeless if he/she lacks a fixed, regular and adequate nighttime residence and/or his/her primary nighttime residence is either of the following: (1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations; (2) an institution that provides a temporary residence for individuals intended to be institutionalized; or (3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street).
FosterHome	Foster Home: When a client lives in a home other than that of the client's family. This includes therapeutic foster care facilities/home.
NursingHome	Nursing Home: An establishment that provides living quarters and care for the elderly and the chronically ill.
HomeWithFamily	Home with family: When a client lives with parents, relatives, adopted family, or legal guardian.
Level123TreatmentSetting	Level 1, 2, 3 Treatment Settings: Level facilities provide a structured treatment setting with daily 24-hour supervision and an intensive treatment program, including medical support services. Level 1 facility includes the following subcategories: (a) hospitals; (b) sub-acute facilities; and (c) residential treatment centers. Level 2 Behavioral Health Residential facilities provide structured treatment setting with 24-hour supervision and counseling or other therapeutic activities for clients who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional. Level 3 Behavioral Health Residential facilities provide continuous 24-hour supervision and treatment in a group residential setting to clients who are determined to be capable of independent functioning but still need some protective oversight to insure they receive needed services.
TransitionalHousingLevelIV	Transitional housing (Level IV) or DES group homes for children refer to a shelter/housing arrangement for short-term care. This includes DES children group homes, half-way/three-quarter way house, rural substance abuse transitional center, and all others not included in Levels I, 2, and 3 treatment settings.

Data Element	Definition
PermanentHousingForFormerlyHomelessPersons	Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)
PsychiatricHospital	Psychiatric hospital or other psychiatric facility
SATreatmentFacility	Substance abuse treatment facility or detox center
HospitalNonPsychiatric	Hospital (non-psychiatric)
HotelMotelSelfPay	Hotel or motel paid for without emergency shelter voucher
HomeWithFriends	Staying or living in a friend's room, apartment or house
PlaceNotMeantForHabitation	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside); inclusive of "non-housing service site (outreach programs only)"
SafeHaven	Safe Haven
RentalVASH	Rental by client, with Veterans Affairs Supportive Housing (VASH) housing subsidy.
RentalNonVASH	Rental by client, with other (non-VASH) ongoing housing subsidy. (Veterans Affairs Supportive Housing (VASH))
OwnHomeHousingSubsidyOngoing	Owned by client, with ongoing housing subsidy:
RentalNoHousingSubsidyOngoing	Rental by client, no ongoing housing subsidy

1.3.5.46 ResidenceType

This value set describes the type of residence that the client is in just prior to (i.e., the night before) treatment program admission.

An individual or family who will imminently lose their primary nighttime residence, provided that:
(i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; AND
(ii) No subsequent residence has been identified; AND
(iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing.

From Housing Loss in 14 Days

(Homeless: Imminently At-Risk of Literal Homelessness)

Data Element	Definition
nonChronicHomeless	Non-Chronic Homelessness (Homeless: Literally Homeless) An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; OR (ii) An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals); OR (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.
chronicHomelessness	Chronic Homelessness (Homeless: Literally Homeless) An individual or family who is literally homeless, per 1 (a) above, AND meets the criteria for chronic homelessness. This includes: (i) An individual who: (a) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; AND (b) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years, where each homeless occasion was at least 15 days; AND (c) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability; OR (ii) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (i) of this definition, before entering that facility; OR (iii) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (i) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.
housingLoss14Days	Housing Loss in 14 Days (Homeless: Imminently At-Risk of Literal Homelessness) An individual or family who will imminently lose their primary nighttime residence, provided that: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; AND (ii) No subsequent residence has been identified; AND (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing.
homelessImminentlyAtRiskDomesticViolence	Domestic Violence (Homeless: Imminently At-Risk of Literal Homelessness)

Data Element	Definition
	Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; AND (ii) Has no other residence; AND (iii) Lacks the resources or support networks, e.g., family, friends, faith based or other social networks, to obtain other permanent housing.
homelessAtRisk	Homeless: At-Risk of Literal Homelessness Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who: (i) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a); AND (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance; AND (iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; AND (iv) Can be expected to continue in such status for an extended period of chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment.
housedAtRiskHomelessnessAdultFamily	Housed: At-Risk of Homelessness - Adult/Family An individual or family who: (i) Has an annual income below 30 percent of median family income for the area, as determined by HUD; AND (ii) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in the Homeless: Literally Homeless status above; AND (iii) Meets one of the following conditions: (A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance; (B) Is living in the home of another because of economic hardship; (C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; (D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by Federal, State, or local government programs for low-income individuals; (E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 persons reside per room, as defined by the U.S. Census Bureau; (F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

Data Element	Definition
	(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.
housedAtRiskHomelessnessYouth	Housed: At-Risk of Homelessness - Youth A child or youth who does not qualify as ''homeless'' under the Homeless: Literally Homeless, Homeless: Imminently At-Risk of Literal Homelessness status' above, but qualifies as ''homeless'' under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); OR (3) A child or youth who does not qualify as ''homeless'' under the Homeless: Literally Homeless or Homeless: At-Imminent Risk of Literal Homelessness status' above, but qualifies as ''homeless'' under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.
stablyHoused	Stably housed Persons in a stable housing situation and not at risk of losing this housing (i.e., do not meet the criteria for any of the other housing response categories, per above definitions)

1.3.5.47 Problem

This value set specifies the encoded problem attributed to the client - either behavioral health or physical problem (including finding symptom, problem, complaint, condition, diagnosis, functional limitation, etc.).

Problems are encoded using standard-based as is appropriate to the exchange context terminologies (e.g. SNOMED-CT, ICD-9-CM, ICD-10-CM, DSM-IV TR, DSM-5, etc.).

1.3.5.48 Procedure

This value set specifies the procedure/services rendered to behavioral health clients.

Procedures /services are encoded using standard-based terminologies appropriate to the exchange context (e.g. SNOMED-CT, ICD-9-CM Vol.3, ICD-10-PCS, CPT/ HCPCS, LOINC, etc.).

1.3.5.49 ReadingProficiency

This value set is used to specify the client's ability to read.
Finding related to ability to read (SNOMED-CT CID: 365792003)|

Data Element	Definition
AbleToRead	Able to read SNOMED-CT ID: 309251006 [clinical finding]

Data Element	Definition
UnableToRead	Unable to read SNOMED-CT ID: 309252004 [clinical finding]
DifficultyReading	Difficulty reading SNOMED CT ID: 309253009 [clinical finding]

1.3.5.50 ReferralSource

This value set contains example referral sources for behavioral health encounters is currently state specific.

Many of the example values below are taken from SAMHSA Treatment Episodes Data Set (TEDS) Admission Manual.

Because 'Referral source' is an important concept associated with billing since the source of admission for an encounter may contribute to the level of reimbursement for the service as well. We assume that Referral Source used in behavioral health exchange should be interoperable during exchange with the various agencies and providers that may be involved in a transfer of care of behavioral health clients. As social services become more tightly integrated into the health care delivery process, it may be appropriate to use the National Uniform Billing Committee (NUBC) value set prescribed by CMS billing requirements. The source for this information at the "point of care" - at the time the encounter is registered using values prescribed by CMS (FL-15 Source of Admission - "point of patient origin for the admission or visit of the claim being billed" (e.g., Emergency department referral, transfer from inpatient hospital, outpatient clinic referral, court/law enforcement, etc.).

Data Element	Definition
Self/Family/Friend	
Other Behavioral Health Provider	
Federal Agency	
Child Protective Service Urgent Response	
Criminal justice	
Other	

Data Element	Definition
Community agency	
Health Plan	
Customer Service	GAP Closest map to (9) Information Not Available: The means by which the patient was referred to this hospital's outpatient department is not known.
Department of Education	GAP Closest mapping to current UB-04 value is (9) Information Not Available: The means by which the patient was referred to this hospital's outpatient department is not known.
Employer	GAP
Not Collected	GAP - not in UB-04. Could use a null flavor.

1.3.5.51 RiskBehavior

This value set is used to specify the client's Risk Behaviors. Initial values taken from Adult Needs and Strengths Assessment (ANSA) manual.

Data Element	Definition
SuicideRisk	Suicide Risk
SelfInjurious	Self Injurious
OtherSelfHarm	Other Self Harm
Gambling	Gambling
Exploitation	Exploitation
DangerToOthers	Danger to Others
CriminalBehavior	Criminal Behavior
SexualAggression	Sexual Aggression
IVDrugUse	IV Drug Use
DrugUse	Drug Use

1.3.5.52 RouteOfAdministration

This value set is used to indicate the route of administration that the client uses for substances of abuse. The value set also supports route of administration for medications and immunizations in addition to clients' substances of abuse.

Data Element	Definition
Oral	This code specifies that the substance is taken orally/by mouth.
Smoking	This code specifies that the substance is smoked.
Inhalation	This code specifies that the substance is inhaled.
Injection	This code specifies that the substance is injected (e.g. intravenous, intramuscular).
Intravenous	This code specifies that the substance is injected intravenously.
Intramuscular	This code specifies that the substance is injected intramuscularly.

1.3.5.53 SelfControl

This value set is used to express the client's self control

Data Element	Definition
fullControl	The client is fully committed and able to controlling his/her behavior.
goodControl	Client is generally committed to control his/her behavior; however, may continue to struggle with control in some challenging circumstances.
poorControl	Client is ambivalent about controlling his/her behavior.
noControl	Client not interested in controlling his/her behavior at this time.

1.3.5.54 SeverelyEmotionallyDisturbed (SED)

This value set contains a valid ICD-9-CM diagnosis codes used to classify someone in the severally emotionally disturbed category (SED). This category may be used as a basis for various treatment programs. Starter value set based on subset from Attachment 7.5.3: SMI and SED Qualifying Diagnoses Table. (ICD-9-CM recommended because some values are not found in DSM-IV-TR. Most codes in this table are included in the ICD-9-CM - DSM-IV-TR crosswalk.)

1.3.5.55 SeverelyMentallyIll (SMI)

This value set contains a valid ICD-9-CM diagnosis codes used to classify someone in the severally mentally ill (SMI) category. This category may be used as a basis for various treatment programs. Starter value set based on subset from Attachment 7.5.3: SMI and SED Qualifying Diagnoses Table. (ICD-9-CM recommended because some values are not found in DSM-IV-TR. Most codes in this table are included in the ICD-9-CM - DSM-IV-TR crosswalk.)

1.3.5.56 SexualOrientation

This value set specifies the sexual orientation of a client. (For Age 18 and older) It refers to an enduring pattern, or lack thereof, of a romantic, sexual, and/or emotional attraction to men, women, or all genders and uses the SexualOrientation value set.

Data Element	Definition
Asexual	Asexual: a person who is not romantically, sexually, and/or emotionally attracted to persons of any gender.
Bisexual	Bisexual: a person who is romantically, sexually, and/or emotionally attracted to men, women, or all genders/gender identities.
Gay	Gay: a man who is romantically, sexually, and/or emotionally attracted to persons of the same gender/gender identity.
Heterosexual	Heterosexual: a person who is romantically, sexually, and/or emotionally attracted to persons of the opposite gender/gender identity.
Lesbian	Lesbian: a woman who is romantically, sexually, and/or emotionally attracted to persons of the same gender/gender identity.
Questioning	Questioning: a person who is questioning his or her sexual orientation.
Decline to Answer	Decline to Answer: a person who did not answer the question; or a person who declined to answer the question.
Not Applicable	Not Applicable Due to Age: Ages 0 thru 17

1.3.5.57 StateProgram

This value set placeholder identifies the programs that a client receives from state agencies. This information is used in coordination of benefits (see Social History - otherProgramCoordination) and is an optional element. Clients may be enrolled in more than one program concurrently.

This value set is state-specific and the following example values are for illustrative purposes.

Data Element	Definition

Data Element	Definition
DES	Department of Economic Security programs
RSA	Rehabilitative Services Administration programs
LTC	Long Term Care Services programs
FESP	Federal Emergency Services Program (FESP)
KidsCare	Title XXI (KidsCare) program
AcuteCareServices	Acute Care Services program
SMI	Severe Mental Illness program
SED	Severely Emotionally Disturbed program

1.3.5.58 SubmissionTrigger

This value is used to reflect the state of the Behavioral Health Report (Initial demographics submission for Crisis client, Full Assessment report for Behavioral Health client, End of Episode report for Behavioral Health client, etc.)

Data Element	Definition
NewEpisodeStart	The first assessment of the client's Descriptive Characteristics and Outcome Measures. (submit initial demographics-->New Episode of Care Reported)
EpisodeEnd	Assessment of client's Descriptive Characteristics and Outcome Measures conducted at Closure. (end of episode-->End of Episode Reported)
FullAssessment	An annual or significant change review that is a documented update of a client's behavioral health assessment, treatment and progress toward meeting defined service goals over the past year. In addition to meeting with the client and other team members this involves a review of the client's behavioral health record including assessments, progress notes, medications, service plans and reviews, demographic and clinical data elements for the past 12 months. (periodic-->Full Assessment Reported)
Correction/Update	Assessment sent to correct a previous Full Assessment Reported. (change in client status OR periodic update/correction-->Full Assessment Reported)
Crisis	Assessment sent during a crisis encounter. (start crisis-->Crisis)

1.3.5.59 SubstanceAbuseDisorders

This value set contains the valid diagnosis codes used to define substance of abuse disorders.

This category may be used as a basis for various treatment programs. The starter value set is based on Attachment 7.5.4: Substance Abuse Disorders Qualifying Diagnoses Table.

Once the ICD-10-CM and DSM-5 code systems have been implemented and are used in exchange, this value set will be updated accordingly.

1.3.5.60 SubstanceOfAbuse

This value set identifies an example set of commonly referenced/reported psychoactive substances that may be abused by a person who is participating in and receiving behavioral health services.

These values may be mapped to a standards-based SubstanceOfAbuse value set.

Data Element	Definition
Alcohol	Alcohol
Cocaine/Crack (CNS Stimulants)	Cocaine/Crack (CNS Stimulants)
Marijuana/Hashish	Marijuana/Hashish
Heroin/Morphine (Opiates/Narcotics)	Heroin/Morphine (Opiates/Narcotics)
Other Opiates/Synthetics	Other Opiates/Synthetics
Methamphetamine/Speed (CNS Stimulants	Methamphetamine/Speed (CNS Stimulants
Hallucinogens	Hallucinogens
Other Stimulants	Other Stimulants
Benzodiazepines (CNS Depressants)	Benzodiazepines (CNS Depressants)
Inhalants	Inhalants

Data Element	Definition
Sedatives/Tranquilizers (CNS Depressants)	Sedatives/Tranquilizers (CNS Depressants)
Other Drugs	Other Drugs

1.3.5.61 TobaccoUseExposure

This list will contain all values descending from the SNOMED CT® 365980008 tobacco use and exposure - finding hierarchy. Referenced in Meaningful Use and Consolidated CDA.

Data Element	Definition
ChewsTobacco	Chews tobacco - SNOMED-CT 81703003 [clinical finding]
SnuffUser	Snuff user - SNOMED-CT 228494002 [clinical finding]
CigarSmoker	Cigar smoker - SNOMED-CT 59978006 [clinical finding]
PassiveSmoker	Passive smoker - SNOMED-CT 43381005 [clinical finding]
HeavyCigaretteSmoker	Heavy cigarette smoker - SNOMED CT 230063004 [clinical finding]
NonSmoker	Non-Smoker - SNOMED CT 8392000 [clinical finding]
ModerateSmoker (20 or less per day)	Moderate smoker (20 or less per day) SNOMED-CT Concept ID: 56578002
Pipe smoker	Pipe smoker - SNOMED-CT Concept ID: 82302008 [clinical finding]
ExSmoker	Ex-smoker - SNOMED-CT ID: 8517006 [clinical finding]

1.3.5.62 TreatmentModality

The TreatmentModality value set is used to describe type of services planned for a Behavioral Health client. Example values gleaned from sections A & K - SERVICES PLANNED & SERVICES RECEIVED in CSAT GPRA Client Outcome Measures for Discretionary Programs Codebook. This element is only collected upon "admission".

Data Element	Definition
CaseManagement TreatmentModality	

Data Element	Definition
DayTreatmentServices	Day Treatment Services
InpatientHospitalOtherThanDetox	Inpatient/Hospital (Other than Detox)
OutpatientServices	Outpatient Services
OutreachServices	Outreach Services
IntensiveOutpatientServices	Intensive Outpatient Services
MethadoneTreatmentServices	Methadone Treatment Services
ResidentialRehabilitationServices	Residential/Rehabilitation Services
DetoxificationHospitalInpatientServices	Detoxification: Hospital Inpatient Services
FreeStandingResidentialServices	Free Standing Residential Services
DetoxificationAmbulatoryDetoxificationServices	Detoxification: Ambulatory Detoxification Services
AfterCareServices	After Care Services
RecoverySupportServices	Recovery Support Services

1.3.5.63 TreatmentParticipation

The TreatmentParticipation value set specifies the method or reason used to determine the client's participation in a behavioral health program. This value set was renamed from "ParticipationCode" to clarify its purpose as well as to distinguish it from any relationship to the HL7 reserved term, "Participation".

Data Element	Definition
Voluntary	Voluntary participation is when a client (or a parent/guardian, if applicable) is applying for or receiving services voluntarily.
InvoluntaryCriminal	Involuntary – Criminal; DUI/ Drug Court /condition of parole/probation is when a client applies for/receives services as a result of criminal court ordered treatment OR when a client applies for/receives services as a result of a court ordered DUI screening, education or treatment.

Data Element	Definition
InvoluntaryCivil	Involuntary - Civil/Mental Health Court Order is when a client applies for/receives services as a result of Title 36 proceedings for a court ordered evaluation (COE) or court ordered treatment (COT).

1.3.5.64 TreatmentService

The TreatmentService value set is used to describe the type of treatment service provided to Behavioral Health clients. At least one treatment service must be selected at time of Intake (admission) and at discharge.

Example values are drawn from the CSAT GPRA Client Outcome Measures for Discretionary Programs Codebook.

Data Element	Definition
Screening	Screening
BriefIntervention	Brief Intervention
BriefTreatment	Brief Treatment
ReferralToTreatment	Referral to Treatment
TreatmentRecoveryPlanning	Treatment/Recovery Planning
IndividualCounseling	Individual Counseling
GroupCounseling	Group Counseling
FamilyAndMarriageCounseling	Family/Marriage Counseling
CoOccurringTreatmentRecoveryServices	Co-Occurring Treatment/Recovery Services
PharmacologicalInterventions	Pharmacological Interventions
HIVAIDSCounseling	HIV/AIDS Counseling

1.3.5.65 Code Systems

The following standards-based code systems are referenced in various value sets contained within this analysis.

1.3.5.65.1 CPT

This represents the Current Procedural Terminology-4 (CPT-4) code system.

The CPT is a uniform coding system consisting of descriptive terms and identifying codes used primarily to identify medical services and procedures furnished by physicians and other health care professionals which are billed to public or private health insurance programs (payers). CPT-4 is copyrighted, maintained and licensed by the American Medical Association and the codes are republished and updated annually on January 1.

2013 brings major changes to the entire family of psychiatry codes in CPT.

Data Element	Definition
2.16.840.1.113883.6.12	CPT Code System OID [2.16.840.1.113883.6.12]

1.3.5.65.2 DSM

The Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, provides a common language and standard criteria for the classification of mental disorders.

The DSM evolved from systems for collecting census and psychiatric hospital statistics, and from a United States Army manual. Revisions since its first publication in 1952 have incrementally added to the total number of mental disorders, although revisions have also removed those no longer considered to be mental disorders.

The coding system used in the DSM is designed to correspond with the codes used in the ICD, although not all codes may match at all times because the two publications are not revised synchronously.

The current version of DSM, published on May 18, 2013, is the DSM-5 (fifth edition). DSM-IV TR, published in 2000, remains the most currently implemented version (for use in billing) at the time this domain analysis model is published.

This domain analysis supports DSM-IV, DSM-IV TR and DSM-5 coding schemes.

1.3.5.65.3 DSM-IV

The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision) published in 1994, is a multi-axial system that tries to address "the whole person". It grows out of the professional conviction that, in order to intervene successfully in an emotional or psychiatric disorder, we need to consider the affected person from a variety of perspectives.

Many mental health professionals use the DSM manual to determine and help communicate a patient's diagnosis after an evaluation; hospitals, clinics, and insurance companies in the US also generally require a 'five axis' DSM diagnosis of all the patients treated.

Data Element	Definition
2.16.840.1.113883.6.126	DSM-IV Code System OID: [2.16.840.1.113883.6.126]

1.3.5.65.4 DSM IV TR

The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision) published in 2000 is a "text revision" of the DSM-IV.

Diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged. The text sections giving extra information on each diagnosis were updated, as were some of the diagnostic codes to maintain consistency with the ICD.

DSM-IV-TR organized each psychiatric diagnosis into a five-part axial system (dimensions or axes) relating to different aspects of disorder or disability.

The first axis incorporated clinical disorders. The second axis covered personality disorders and intellectual disabilities. The remaining axes covered medical, psychosocial, environmental, and childhood factors functionally necessary to provide diagnostic criteria for health care assessments.

- **Axis I:** All diagnostic categories except mental retardation and personality disorder
- **Axis II:** Personality disorders and mental retardation (although developmental disorders, such as Autism, were coded on Axis II in the previous edition, these disorders are now included on Axis I)
- **Axis III:** General medical condition; acute medical conditions and physical disorders
- **Axis IV:** Psychosocial and environmental factors contributing to the disorder

- **Axis V:** Global Assessment of Functioning or Children's Global Assessment Scale for children and teens under the age of 18

1.3.5.65.5 DSM-5

On May 18, 2013, DSM-5 was published superseding DSM-IV (published 1994) and DSM-IV TR (published 2000).

DSM-5 is available for purchase from the American Psychiatric Association at www.appi.org.

Overall changes expected to DSM-5:

1. DSM-5 calls for the generation of acceptable definitions for 'mental disorder', 'disease' and 'illness'.
2. **DSM-5 will collapse (eliminate) Axes I, II, and III into one axis that contains all psychiatric and general medical diagnoses**.
3. **DSM-5 will move to a non-axial documentation of diagnosis**, combining the former Axes I, II, and III, with separate notations for psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V). This change would bring DSM-5 into greater harmony with the single-axis approach used by the international community in the World Health Organization's (WHO) International Classification of Diseases (ICD).
4. DSM-5's 20 chapters will be restructured based on disorders' apparent relatedness to one another, as reflected by similarities in disorders' underlying vulnerabilities and symptom characteristics.

DSM-5 code system OID not yet assigned.

1.3.5.65.6 HCPCS

This represents the Healthcare Common Procedure Coding System (HCPCS) code system.

The HCPCS is divided into two principal subsystems, referred to as level I and level II of the HCPCS.

Level I is comprised of CPT-4 (which does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians).

Level II of the HCPCS is a standardized coding system maintained by CMS that is primarily used to represent items, supplies and non-physician services not covered by the American Medical Association's CPT-4 codes.

Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

In October of 2003, the Secretary of Health and Human Services delegated authority under the HIPAA legislation to CMS to maintain and distribute HCPCS Level II Codes.

Data Element	Definition
2.16.840.1.113883.6.14	HCPCS Code System OID [2.16.840.1.113883.6.14]

1.3.5.65.7 HL7

This represents the root OID for HL7 Version 3 vocabulary code systems and value sets.

Data Element	Definition
2.16.840.1.113883	HL7 Version 3 Root OID [2.16.840.1.113883]

1.3.5.65.8 ICD

The International Statistical Classification of Diseases and Related Health Problems (ICD), produced by the World Health Organization (WHO), is an international standard in diagnostic classification for health reporting and clinical applications for all medical diagnoses, including mental health and behavioral disorders and procedures.

The ICD is revised periodically to incorporate changes in the medical field. To date, there have been 10 revisions of the ICD.

The 11th revision of ICD classification has already started and will continue until 2015.

1.3.5.65.9 ICD-9-CM Vol 1&2

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9).

ICD-9-CM is comprised of three volumes. Volumes 1 & 2 contain Diagnosis codes.

ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization and for billing in the United

States until October 1, 2014 when ICD-10-CM is slated to supersede ICD-9-CM (vols. 1 & 2).

Data Element	Definition
2.16.840.1.113883.6.103	ICD-9-CM Diagnosis Code Set – Vol. 1 & 2 OID [2.16.840.1.113883.6.103]

1.3.5.65.10 ICD-9-CM Vol 3

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9).

ICD-9-CM is comprised of three volumes. Volume 3 contains Procedure codes.

ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization and for billing in the United States until October 1, 2014 when ICD-10-PCS is slated to supersede ICD-9-CM (vol. 3).

Data Element	Definition
2.16.840.1.113883.6.104	ICD-9-CM Procedure Code Set – Vol. 3 OID [2.16.840.1.113883.6.104]

1.3.5.65.11 ICD-10-CM

ICD-10-CM is planned as the replacement for ICD-9-CM, volumes 1 and 2.

ICD-10 is copyrighted by the World Health Organization (WHO), which owns and publishes the classification. ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States starting in 1994.

WHO authorized the development of an adaptation of ICD-10 for use in the United States for U.S. government purposes as ICD-10-CM.

Beginning October 1, 2014, all covered entities under the Health Insurance Portability and Accountability Act (HIPAA) must convert to using the ICD-10-CM diagnosis codes for a variety of clinical and health care applications for reporting, morbidity statistics, and billing.

Data Element	Definition
2.16.840.1.113883.6.3	ICD-10 (Diagnoses) Code System OID [2.16.840.1.113883.6.3]

1.3.5.65.12 ICD-10-PCS

ICD-10-PCS is the successor to Volume 3 of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

Beginning October 1, 2014, all covered entities under the Health Insurance Portability and Accountability Act (HIPAA) must convert to using the ICD-10-PCS procedure codes for a variety of clinical and health care applications for reporting, morbidity statistics, and billing.

Data Element	Definition
2.16.840.1.113883.6.4	ICD-10-PCS (Procedures) Code System OID [2.16.840.1.113883.6.4]

1.3.5.65.13 ISO 639-2

ISO 639 is a standardized nomenclature used to classify all known languages. Each language is assigned a 2-letter (639-1) and 3-letter (639-2 and 639-3), lowercase abbreviation.

Recommendation:

ISO 639-2
Code System: Internet Society [2.16.840.1.113883.6.121]
Value Set: 2.16.840.1.113883.1.11.11526

Note: ISO 639-2 is the alpha-3 code in Codes for the representation of names of languages-- Part 2. There are 21 languages that have alternative codes for bibliographic or terminology purposes. In those cases, each is listed separately and they are designated as "B" (bibliographic) or "T" (terminology). In all other cases there is only one ISO 639-2 code. Multiple codes assigned to the same language are to be considered synonyms. ISO 639-1 is the alpha-2 code.

See: *http://www.loc.gov/standards/iso639-2/php/code_list.php*

Data Element	Definition
2.16.840.1.113883.1.11.11526	ISO 639-2, referenced in July 2012 C-CDA and in U.S. Meaningful Use demographic data collection standards. **Code System:** Internet Society Language [2.16.840.1.113883.1.11.1] **Value Set:** Language [2.16.840.1.113883.1.11.11526] DYNAMIC

1.3.5.65.14 LOINC

Logical Observation Identifiers Names and Codes, or LOINC, published by the Regenstrief Institute, is a set of unique codes and names to identify laboratory and other clinical observations. LOINC was initiated by

Regenstrief Institute research scientists who continue to develop it with the collaboration of the LOINC Committee.

Data Element	Definition
2.16.840.1.113883.6.1	LOINC Code System OID [2.16.840.1.113883.6.1]

1.3.5.65.15 NUBC

The National Uniform Billing Council (NUBC) was formed to develop a single billing form and standard data set that could be used nationwide by institutional providers and payers for handling health care claims.

In 1982, the NUBC approved the Uniform Billing (UB) data set and form designed to convey a core set of data containing pertinent information about patient services, the clinical basis for treatment, related events surrounding the care, as well as other information typically needed by third-party payers, and health researchers. The first adopted data set and form was the UB-82 in use for 10 years. Its successor the UB-92 form was in use for 12 years. The current form is the UB-04.

See: http://www.nubc.org/

Code System: NUBC UB-04 Manual: [2.16.840.1.113883.6.301]

Value Sets:

- NUBC Admission Source OID [2.16.840.1.113883.6.301.4]
- NUBC Patient Discharge Status OID [2.16.840.1.113883.6.301.5]

Data Element	Definition
2.16.840.1.113883.6.301.4	NUBC Admission Source OID: [2.16.840.1.113883.6.301.4] FL 15
2.16.840.1.113883.6.301.5	NUBC Patient Discharge Status OID [2.16.840.1.113883.6.301.5] FL 17

1.3.5.65.16 NUCC

The National Uniform Claim Committee (NUCC) is a voluntary organization created to develop a standardized data set for use by the non-institutional health care community to transmit claim and encounter information to and from all third-party payers (i.e., individual providers). The NUCC is chaired by the American Medical Association (AMA), with the Centers for Medicare and Medicaid Services (CMS) as a critical partner. The committee is a diverse group of health care industry stakeholders representing providers,

payers, designated standards maintenance organizations, public health organizations, and vendors.

The NUCC was formally named in the administrative simplification section of the HIPAA of 1996 as one of the organizations to be consulted by the American National Standards Institute's accredited SDOs and the Secretary of HHS as they develop, adopt, or modify national standards for health care transactions.

The Health Care Provider Taxonomy code set is an external, non-medical data code set designed for use in an electronic environment, specifically within the ASC X12N Health Care transactions. This includes the transactions mandated under HIPAA. The Healthcare Provider Taxonomy code set divides health care providers into hierarchical groupings by type, classification, and specialization, and assigns a code to each grouping. The Taxonomy consists of two parts: individuals (e.g., physicians) and non-individuals (e.g., ambulatory health care facilities). The Health Care Provider Taxonomy code is a unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification, and Area of Specialization.

Code System:

- NUCC Health Care Provider Taxonomy OID: [2.16.840.1.113883.6.101]

Data Element	Definition
2.16.840.1.113883.6.101	NUCC Health Care Provider Taxonomy OID [2.16.840.1.113883.6.101]

1.3.5.65.17 RxNorm

This is the RxNorm code system used to represent medications documented in a Medication summary section of a document.

RxNorm is the required standard for reporting medications cited in the U.S. Meaningful Use program measures.

RxNorm is two things: a normalized naming system for generic and branded drugs; and a tool for supporting semantic interoperation between drug terminologies and pharmacy knowledge base systems. The National Library of Medicine (NLM) produces RxNorm. For more information on RxNorm see: https://www.nlm.nih.gov/research/umls/rxnorm/

Items from this list can also be used to capture specific substances of abuse when those substances are prescription medications (or anything coded using RxNorm), although abused substances are generally reported in a separate section of a document intended for exchange (i.e., abused substances are not included in Medication List but appear in a separate section within Social History information.

Code System:

- RxNorm: [2.16.840.1.113883.6.88]

Data Element	Definition
2.16.840.1.113883.6.88	RxNorm Code System OID [2.16.840.1.113883.6.88]

1.3.5.65.18 SNOMED-CT

SNOMED Clinical Terms (SNOMED CT) is a comprehensive, multilingual clinical healthcare terminology that is intended to contribute to the improvement of patient care by underpinning the development of Electronic Health Records that record clinical information in ways that enable meaning-based retrieval. SNOMED CT is owned, maintained and distributed by the International Health Terminology Standards Development Organisation (IHTSDO).

Code system:

- SNOMED-CT: [2.16.840.1.113883.6.96]

Data Element	Definition
2.16.840.1.113883.6.96	SNOMED-CT OID [2.16.840.1.113883.6.96]

1.4 Annex A: Behavioral Health Report - Life Cycle

This section describes the various triggers for exchanging behavioral health summary records/documents that conforms to this domain analysis model.

A Behavioral Health record/report undergoes specific changes over time. These changes are represented as state transitions.

State transitions correspond to trigger events. In other words, they initiate information exchange. Figure 16 depicts the life cycle of a Behavioral Health Report and shows the trigger events associated with each state transition.

Note: This section has not been updated for the Second Informative ballot, and as yet to be defined are the additional trigger events that may initiate exchange between providers caring for behavioral health clients and the various social service agencies that serve behavioral health clientele. The following four state transitions are depicted in the Behavioral Heath Report lifecycle.

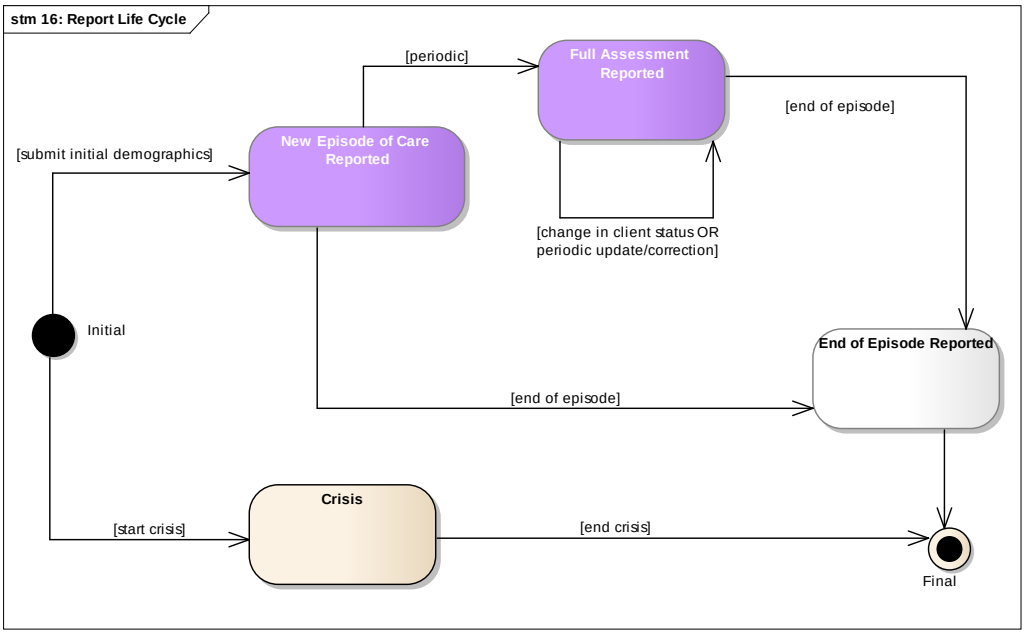

Figure 16: Report Life Cycle

1.4.1 New Episode of Care Reported

The full complement of core data including demographic information are submitted when a new episode of care is initiated.

1.4.2 Full Assessment Reported

Periodically, when appropriate, a full client assessment and related report is submitted.

1.4.3 End of Episode Reported

The Episode of Care ends and a reason is recorded using one of the values of the "EpisodeCompletionCode".

1.4.4 Crisis

A crisis encounter may occur during a Behavioral Health Episode of Care. Documenting a crisis is very important and information related to a crisis event should be conveyed via information exchange to the Behavioral Health organization and provider responsible for been fully analyzed at this time, but this has been included in this analysis to delineate a Crisis encounter from a routine behavioral health care encounter that takes place during a client's episode of care.

1.4.5 Initial

This is the event that begins the Behavioral Health Episode of Care.

1.4.6 Final

This is the event that completes the Behavioral Health Episode of Care.

1.5 Annex B: Glossary

1.5.1 Crosswalk

A crosswalk is a map between code systems, designed to determine which codes from one system correspond to codes in another system (for example, from DSM-IV TR to ICD-9-CM).

Crosswalks are useful when encoded information is captured in one coding scheme but must be communicated using a different code system under certain conditions, such as for billing, or to comply with jurisdictional health information exchange policies such as the U.S. EHR-S Meaningful Use criteria which requires the use of various standards-based code systems such as SNOMED-CT and RxNorm.

1.5.2 Episode Of Care

An Episode of Care in the context of Behavioral Heath reporting is defined as the period between the beginning and end of Behavioral Health services treatment for an individual. Within an episode of care, a person may transfer to a different service, facility, program or location.

1.5.3 First Listed Diagnosis

The First-listed diagnosis is a current term of art for what commonly has been referred to as Primary diagnosis. First-listed diagnosis is the main condition treated or investigated during the relevant episode of outpatient (ambulatory) health care.

Where there is no definitive diagnosis, the main symptom or sign, abnormal findings, or problem is reported as the first-listed diagnosis. The first-listed diagnosis is reported by physician offices, ambulatory care centers, outpatient hospital settings, etc.

See Primary diagnosis for more information on use in inpatient settings along with Principal diagnosis.

1.5.4 Primary Diagnosis

Primary diagnosis is an outdated term used in outpatient settings. The term was changed to First-listed diagnosis some years ago, which is defined as the main condition treated or investigated during the relevant episode of outpatient (ambulatory) health care. Where there is no definitive diagnosis, the main symptom or sign, abnormal findings, or problem is reported as the first-listed diagnosis. The first-listed diagnosis is reported by physician offices, ambulatory care centers, outpatient hospital settings, etc.

In an inpatient setting, the term "Primary Diagnosis" is still used to reference the condition that was the most serious and/or resource intensive during that hospitalization.

An example of the difference between Primary and Principal diagnoses in inpatient coding is a patient admitted to the hospital for a surgical procedure such as gallbladder surgery and then, in the post operative period, suffers a heart attack. The primary diagnosis would be the heart attack because it will require more services, more consultations, more medications, etc., as well as a longer hospital confinement and is more serious than the gallbladder diagnosis. However, the principal diagnosis is the problem with the gallbladder since that is what originally brought the patient into the hospital. Heart attack would be listed as a relevant secondary diagnosis.

1.5.5 Principal Diagnosis

"Principal diagnosis" (PDX) for inpatient care is defined as that condition established after study to be chiefly responsible for the admission to the hospital. An important part of the definition above is the phrase "after study," which directs coders to review all patient record documentation

associated with an inpatient hospitalization to determine the definitive clinical condition that was the documented reason for the admission.

The term "Primary diagnosis" is an outdated term used in mainly in outpatient settings. The term was changed to First-listed diagnosis some years ago, defined as the main condition treated or investigated during the relevant episode of outpatient (ambulatory) health care. Where there is no definitive diagnosis, the main symptom or sign, abnormal findings, or problem is reported as the first-listed diagnosis. The first-listed diagnosis is reported by physician offices, ambulatory care centers, outpatient hospital settings, etc.

In an inpatient setting, the term "Primary diagnosis" is still used to reference the condition that was the most serious and/or resource intensive during that hospitalization.

An example of the difference between Primary and Principal diagnoses in inpatient coding is a patient admitted to the hospital for a surgical procedure such as gallbladder surgery and then, in the post operative period, suffers a heart attack. The primary diagnosis would be the heart attack because it will require more services, more consultations, more medications, etc., as well as a longer hospital confinement and is more serious than the gallbladder diagnosis. However, the principal diagnosis is the problem with the gallbladder since that is what originally brought the patient into the hospital. Heart attack would be listed as a relevant secondary diagnosis.

1.6 Annex C: Value Set Recommendations

The following section describes the initial analysis of vocabulary requirements described in the Value Set Analysis section above. Each of the following identically named value sets is intended to specify the standard terms that were mapped to the initial starter set concepts for use in exchanging coded information.

This annex exemplifies the approach used by our project team to relate stakeholder requirements to standard terminology (e.g. LOINC, ICD, SNOMED-CT) that will help to ensure interoperability.

Figure 8 depicts the requirements for coded elements included in the DAM during the initial phase of the project along with standard value sets that fulfill those requirements.

1.6.1 AdministrativeGender

AdministrativeGender value set is used to specify the gender of a person used for administrative purposes as opposed to the clinical gender of a person.

Recommendation:

- **Code system**: HL7 V3 AdministrativeGender *[2.16.840.1.113883.5.1]*
- **Value Set:** AdministrativeGender *[2.16.840.1.113883.1.11.1]*

Data Element	Definition
F	HL7 V3 Value Set: AdministrativeGender Value Set [2.16.840.1.113883.5.1] Code: F (Female)
M	HL7 V3 Value Set: AdministrativeGender Value Set [2.16.840.1.113883.5.1] Code: M (Male)
UN	HL7 V3 Value Set: AdministrativeGender Value Set [2.16.840.1.113883.5.1] UN (Undifferentiated)

1.6.2 AssessmentCriticalFlag

This value set is used to identify the immediate risk of a critical nature.

Recommendation:

Code System: SNOMED-CT
Values: concepts under the SNOMED-CT hierarchy: 285261008 (dangerous and harmful thoughts) [clinical finding]

Data Element	Definition

Data Element	Definition
425104003 (suicidal behavior)	SNOMED-CT: 425104003 (Suicidal behavior) [clinical finding]
424241004 (homicidal behavior)	SNOMED-CT: 424241004 (Homicidal behavior) [clinical finding]
65108000 (at risk for violence)	SNOMED-CT: 65108000 (at risk for violence) [clinical finding]
129709009 (at risk for self-directed violence)	SNOMED-CT: 129709009 (at risk for self-directed violence) [clinical finding]
129708001 (at risk for self-mutilation)	SNOMED-CT: 129708001 (at risk for self-mutilation) [clinical finding]
161051006 (at risk for violence in the home)	SNOMED-CT: 161051006 (at risk violence in the home) [clinical finding]
285263006 (at risk for violence)	SNOMED-CT: 285263006 (thoughts of violence) [clinical finding] This code has a number of more granular sub-values.

1.6.3 AssessmentRespondent

This value set identifies the type of person who responded to an assessment instrument, whether this is clinician administered or self-report assessment. This is captured because the respondent may not be the target of the assessment (e.g., parent responding for child, etc.).

There are a number of HL7 value sets using HL7 code system: RoleCode [2.16.840.1.113883.5.111].

Recommendation:

Add new HL7 value set that is specific to Assessment Respondent.

Rationale:

C-CDA points to Code System: HL7 V3 RoleCode [2.16.840.1.113883.5.111] and PersonalRelationshipRoleType value set [2.16.840.1.113883.1.11.19563] for use in the RecordTarget for the Guardian element.

This may be a good value set for Assessment Respondent, but any gaps will filled through the HL7 harmonization process.

Alternatively, there are other value sets within HL7 V3 RoleCode that may be mapped the enumerated values identified as gaps.

Data Element	Definition
subject (self)	**Code System:** HL7 Role Code [2.16.840.1.113883.5.111] **Code**: subject
PRN (parent)	**Code System:** HL7 Role Code [2.16.840.1.113883.5.111] **Value Set:** Parent [2.16.840.1.113883.1.11.16346] **Code:** PRN
FTH (father)	**Code System:** HL7 Role Code [2.16.840.1.113883.5.111] **Value Set:** Parent [2.16.840.1.113883.1.11.16346] **Code:** FTH
MTH (mother)	**Code System:** HL7 Role Code [2.16.840.1.113883.5.111] **Value Set:** Parent [2.16.840.1.113883.1.11.16346] **Code:** MTH

1.6.4 BHAssessmentType

This value set is used to represent codes for pertinent Behavioral Health assessment instruments.

Recommendation:

Code System: LOINC [2.16.840.1.113883.6.1]

Each authority is free to use which ever assessment instrument they choose, but each unique instrument should be added to LOINC (if missing) to promote interoperability.

The following assessments included in the proposed enumerated list of assessment instruments have been mapped to standards-based LOINC codes. Change requests will be submitted for the GAPS.

Data Element	Definition
44249-1 (PHQ-9)	**LOINC:** 44249-1 PHQ-9 quick depression assessment panel-Reported Score is reported using LOINC 44261-6 Patient Health Questionnaire 9 item (PHQ-9) total score - Reported
71757-9 (M3 Screen)	**LOINC:** 71757-9 M3 Depression Score
48542-5 (GDS)	48542-5 Geriatric depression scale (GDS) panel
72107-6 (MMSE)	**LOINC:** 72107-6 Mini-Mental State Examination-MMSE

1.6.5 Attitude

This value set is used to describe the client's mental attitude.

Recommendation:

Code System: SNOMED-CT [2.16.840.1.113883.6.96]

Data Element	Definition
Negative attitude	SNOMED-CT: 225462008 (negative attitude) [clinical finding]
Positive attitude	SNOMED-CT: 225463003 (positive attitude) [clinical finding]

1.6.6 Axis-III

This value set represents problems associated with Axis III in the DSM-IV Code System.

Axis III lists any medical or neurological problems that may be relevant to the individual's current or past psychiatric problems; for example, someone with severe asthma may experience respiratory symptoms that are easily confused with a panic attack, or indeed, which may precipitate a panic attack.

In this model Axis-III diagnoses are represented by the physicalProblem element in the ProblemsDiagnoses domain of the summary behavioral health document.

OID: [2.16.840.1.113883.6.126]

1.6.7 Axis-V

This value set is associated with the score from the Global Assessment of Functioning (GAF).

Axis V codes the "level of function" the individual has attained at the time of assessment, and, in some cases, is used to indicate the highest level of function in the past year. This is coded on a 0-100 scale, with 100 being nearly "perfect" functioning.

Data Element	Definition
91-100	Person has no problems OR has superior functioning in several areas OR is admired and sought after by others due to positive qualities.
81-90	Person has few or no symptoms. Good functioning in several areas. No more than "everyday" problems or concerns.

Data Element	Definition
71-80	Person has symptoms/problems, but they are temporary, expectable reactions to stressors. There is no more than slight impairment in any area of psychological functioning.
61-70	Mild symptoms in one area OR difficulty in one of the following: social, occupational, or school functioning. BUT, the person is generally functioning pretty well and has some meaningful interpersonal relationships.
51-60	Moderate symptoms OR moderate difficulty in one of the following: social, occupational, or school functioning.
41-50	Serious symptoms OR serious impairment in one of the following: social, occupational, or school functioning.
31-40	Some impairment in reality testing OR impairment in speech and communication OR serious impairment in several of the following: occupational or school functioning, interpersonal relationships, judgment, thinking, or mood.
21-30	Presence of hallucinations or delusions which influence behavior OR serious impairment in ability to communicate with others OR serious impairment in judgment OR inability to function in almost all areas.
11-20	There is some danger of harm to self or others OR occasional failure to maintain personal hygiene OR the person is virtually unable to communicate with others due to being incoherent or mute.
01-10	Persistent danger of harming self or others OR persistent inability to maintain personal hygiene OR person has made a serious attempt at suicide.

1.6.8 Confidentiality

The Confidentiality value set is used as metadata to indicate the receiver responsibility to comply with normally applicable jurisdictional privacy law or disclosure authorization or to indicate that the receiver may not disclose this information except as directed by the information custodian (who may be the information subject).

Code System: Confidentiality Code [2.16.840.1.113883.5.25]
Value Set: BasicConfidentialityKind [2.16.840.1.113883.1.11.16926] STATIC (2010-04-21)

Data Element	Definition
R	Restricted: Privacy metadata indicating highly sensitive, potentially stigmatizing information, which presents a high risk to the information subject if disclosed without authorization. May be preempted by jurisdictional law, e.g., for public health reporting or emergency treatment. Restricted is the default value for confidentiality of client behavioral health information.
N	Normal: Privacy metadata indicating that the information is typical, non-stigmatizing health information, which presents typical risk of harm if disclosed without authorization.

Data Element	Definition
V	Very Restricted: Privacy metadata indicating very restricted access as declared by the Privacy Officer of the record holder.

1.6.9 CriminalJusticeSystemStatusCodeValueSet

This value set specifies the status of a client within the criminal justice system (incarcerated, on parole, on probation). Values bind to the criminalJusticeSystemInvolvementStatus attribute. This attribute is used in conjunction with criminalJusticeSystemType to fully qualify the client's involvement in the criminal justice system when necessary, e.g. Adult Parole / Juvenile Parole, Adult Incarceration / Juvenile Incarceration, etc. since the age of a client does not determine the jurisdiction.

Recommendation:

Add missing correctional status value (Parole) under sub-hierarchy Concept ID: 365566008 (Prison record and criminal activity details – finding) [Clinical finding]

Data Element	Definition
105509007	The client is on probation. Probation is a decision handed down by the judge at trial. It may be in lieu of jail time or in combination with some jail time. It allows the convicted person to live in the community for a specified period of time under the supervision of a probation officer. Depending on the circumstances and the seriousness of the crime, the judge can specify restrictions on the offender's activities during the probationary period. If an offender violates the conditions or rules of probation, he or she may be sentenced to imprisonment by the judge. This is known as revoking the probation or revocation. SNOMED-CT Concept ID: 105509007 (On probation) [Clinical finding]
45361006	The client confined in a jail or prison; imprisoned. This code is used if client is in the custody of the department of corrections. SNOMED-CT Concept ID: 45361006 (Incarceration) [Clinical finding]
GAP (Parole)	This is a GAP. The client is on parole. Parole is the early release of an inmate who has served part of his or her prison sentence. The inmate is allowed to return to the community under the conditions of parole and the supervision of a parole agent. Violation of these conditions can result in a revocation of the parole and re-imprisonment for the offender. The decision to grant parole is the responsibility of the Parole Commission

1.6.10 CriminalJusticeSystemTypeCodeValueSet

This value set specifies the type of criminal justice system under which the client was adjudicated and is used by the criminalJusticeSystemType attribute (used to delineate adult versus juvenile criminal justice system) contained in the CriminalJusticeSystemInvolvement class.

Recommendation:

Consider concepts found under Concept ID: 410598002 (Person categorized by age) *[Social context]*

Data Element	Definition
133936004	This is a qualifier to distinguish that the client has been adjudicated under the Adult correctional system. SNOMED-CT Concept ID: 133936004 (Adult) [Social context]
133937008	This is a qualifier to distinguish that the client has been adjudicated under the Juvenile correctional system. SNOMED-CT Concept ID: 133937008 (Adolescent) [Social context]

1.6.11 EpisodeOfCareCompletion

This value set describes the "discharge disposition" from the Behavioral Health Treatment episode.

Recommendation:

Use National Uniform Billing Committee (NUBC) UB-04/NUBC CURRENT UB DATA SPECIFICATIONS MANUAL UB-04:

FL 17 – Patient Discharge Status (HITSP-FL-17): disposition or discharge status of the patient at the end service for the period covered on a bill, as reported in FL 6, Statement Covers Period.

Code System: NUBC UB-04 OID: [2.16.840.1.113883.6.301]

NUBC Patient Discharge Status-value set [2.16.840.1.113883.6.301.5]

Data Element	Definition
01 (Treatment completed)	**UB-04:** 01 = Discharged to home or self care (routine discharge)
02 (Transfer)	**UB-04:** 02 = Discharged/transferred to another short-term general hospital 03 = Discharged/transferred to skilled nursing facility (SNF) 04 = Discharged/transferred to an intermediate care facility (ICF) 05 = Discharged/transferred to another type of institution

Data Element	Definition
	06 = Discharged/transferred to home under care of organized home health service organization 09 = Admitted as an inpatient to this hospital (Medicare Outpatient Only) 43 = Discharged to Federal Health Care Facility 50 = Hospice - Home 61 = Discharge to Hospital Based Swing Bed 62 = Discharged to Inpatient Rehab 63 = Discharged to Long Term Care Hospital 64 = Discharged to Nursing Facility 65 = Discharged to Psychiatric Hospital 66 = Discharged to Critical Access Hospital SNOMED-CT: GAP
03 (Transfer)	**UB-04:** 03 = Discharged/transferred to skilled nursing facility (SNF) 03 = Discharged/transferred to skilled nursing facility (SNF) 04 = Discharged/transferred to an intermediate care facility (ICF) 05 = Discharged/transferred to another type of institution 06 = Discharged/transferred to home under care of organized home health service organization 09 = Admitted as an inpatient to this hospital (Medicare Outpatient Only) 43 = Discharged to Federal Health Care Facility 50 = Hospice - Home 61 = Discharge to Hospital Based Swing Bed 62 = Discharged to Inpatient Rehab 63 = Discharged to Long Term Care Hospital 64 = Discharged to Nursing Facility 65 = Discharged to Psychiatric Hospital 66 = Discharged to Critical Access Hospital SNOMED-CT: GAP
04 (Transfer)	**UB-04:** 04 = Discharged/transferred to an intermediate care facility (ICF)
05 (Transfer)	**UB-04:** 05 = Discharged/transferred to another type of institution
06 (Transfer)	**UB-04:** 06 = Discharged/transferred to home under care of organized home health service organization or GAP
07 (Client declined further service)	**UB-04:** 07 = Left against medical advice
07 (Lack of contact)	**UB-04:** 07 = Left against medical advice or GAP in UB-04
20 (Death of Client)	**UB-04:** 20 = Expired
40 (Death of client)	**UB-04:** 40 = Expired at home
41 (Death of Client)	**UB-04:** 41 = Expired in a medical facility; e.g., hospital, SNF, ICF, or free-standing hospice (Medicare Hospice Care Only)
42 (Death of Client)	**UB-04:** 42 = Expired - place unknown (Medicare Hospice Care Only)

Data Element	Definition
GAP (Change in eligibility)	UB-04: GAP SNOMED-CT: GAP
GAP (Crisis End - Referred to Treatment)	
GAP (Incarceration)	UB-04: GAP SNOMED-CT: GAP
GAP (Moved out of area)	UB-04: GAP SNOMED-CT: GAP

1.6.12 EpisodeOfCareType

This value set is used to reflect the type of encounter that triggers the submission of a Behavioral Health Report. It is used to distinguish between encounters that take place during Crisis episodes and routine Behavioral Health episodes.

This information, along with the value associated with the episodeOfCareStatus data element; represents the information that was previously conveyed using the SubmissionTrigger. E.g., New Episode Start/Crisis, New Episode Start/Behavioral Health Episode, End Episode/Crisis, etc.

Recommendation:

Values under **SNOMED-CT** hierarchy 14736009 (patient evaluation and management) [procedure]

Rationale: Many values map to CPT-4 E&M codes.

Data Element	Definition
CrisisEncounter	This value denotes this report as pertaining to a Crisis encounter. SNOMED-CT: 4525004 (emergency department patient visit) [procedure] SNOMED-CT: 4525004 (emergency department patient visit) [procedure]
RoutineBHEncounter	This value describes a routine Behavioral Health client encounter is the reason for Behavioral Health Report submission, used to distinguish from a Crisis encounter. Many values under the SNOMED-CT hierarchy: 14736009 (patient evaluation and management) [procedure] can be used to describe "routine" encounters. There may be GAPS under this hierarchy for Behavioral Health.

1.6.13 FormalEducationLevel

This value set refers to the highest level of formal (school) education completed by the client to date.

Recommendation:

Add missing values under Concept ID: 365460000 (Education received in the past – finding) [Clinical finding] sub-hierarchy.

Data Element	Definition
Age 0-4 - none	
Grades K-3	
Grades 4-6	
Grades 7-8	
Grades 9-12	
High-school Graduate	SNOMED-CT 224297003 (educated to secondary school level) [clinical finding]
Vocational/Technical	SNOMED-CT 440586004 (received vocational training) [clinical finding]
Some College	
Associates/Bachelor Degree	
Graduate/Post-Graduate Degree	SNOMED-CT Concept ID: 440344006 (Received postgraduate education) [Clinical finding]

1.6.14 GenderIdentityValueSet

This value set is used to specify the client's gender identity, otherwise known as core gender identity, and indicates how the client self-identifies. It is not necessarily based on the person's anatomy.

Recommendation

Code System: SNOMED-CT: [2.16.840.1.113883.6.96]

A new SNOMED-CT sub hierarchy could be created under SNOMED-CT 118192006 (Finding relating to self-concept) [Clinical finding] to add missing "Gender Identification" concepts.

Similar terms can be found under other SNOMED concept hierarchies. However those hierarchies may not be appropriate to add the new (missing) concepts if self-identification is an important aspect.

Data Element	Definition
443390004	Decline to Answer: a person who did not answer the question; or a person who declined to answer the question. **Alternative:** HL7 V3 Code System NullFlavor [2.16.840.1.113883.5.1008] Code System Code: ASKU ASKU definition doesn't distinguish between: Subject knows, but declined to answer, and Subject doesn't know the answer. "Information was sought but not found (e.g., client was asked but didn't know) it"
GAP (Gender Variant)	This is a GAP. Gender Variant: a person who self-identifies as both man and woman OR as neither man nor woman.
GAP (Intersex)	This is a GAP. Transgender: a person who lives or self-identifies as a member of a gender other than that expected based on anatomical sex. This term is used by individuals as a term of self-identification and although there is an existing SNOMED-CT Concept ID: 18978002 (Ovotestis or synonym - True hermaphrodite) *[Clinical finding]*, that concept falls under the (Congenital anomaly of body cavity) *[Clinical finding]* sub-hierarchy, and therefore isn't the appropriate sub hierarchy.
GAP (Man)	This is a GAP. Man: a person who self-identifies as a man. Although there is an existing SNOMED-CT Concept ID: 248153007 (Male) *[Clinical finding]*, it falls under SNOMED-CT Concept ID: 429019009 (Finding related to biological sex) *[Clinical finding]* and therefore isn't the appropriate hierarchy given the aspect of self-identification.
GAP (Questioning)	This is a GAP. Questioning: a person who is questioning his or her gender identity. This is not the concept of gender dysphoria defined as discontent with their biological sex and/or the gender they were assigned at birth? (See Wikipedia Gender Identity Disorder)
GAP? (Not Applicable)	Gap? SNOMED-CT Concept ID: 385432009 (Not applicable) [*Qualifier value]* is the closest concept, but does not take age into consideration. Alternative: HL7 V3 Code System NullFlavor *[2.16.840.1.113883.5.1008]*

Data Element	Definition
	Code System Code: NA
GAP (Transgender)	This is a GAP. Transgender: a person who lives or self-identifies as a member of a gender other than that expected based on anatomical sex. Although there are existing SNOMED CT concepts that might be considered, the self-identification aspect deems it unique and therefore this is a gap. Existing concepts include: SNOMED-CT Concept ID: 248091009 (Desire to become member of the opposite sex) *[Clinical finding]* falls under SNOMED-CT Concept ID: 118199002 (Finding relating to sexuality and sexual activity) *[Clinical finding]* sub-hierarchy - not the appropriate sub hierarchy. SNOMED-CT Concept ID: 407374003 (Transsexual) *[Clinical finding]* falls under the sub-hierarchy Concept ID: 429019009 (Finding related to biological sex) *[Clinical finding]* - not the appropriate sub hierarchy. SNOMED-CT Concept ID: 407375002 (Surgically transgendered transsexual) [Clinical finding] falls under the sub hierarchy SNOMED-CT Concept ID: 365873007 (Gender finding) *[Clinical finding]* which is a sub-hierarchy of SNOMED-CT Concept ID: 365860008 (General clinical state finding) *[Clinical finding]*
GAP (Woman)	This is a GAP. Woman: a person who self-identifies as a woman. Although there is an existing SNOMED-CT Concept ID: 248152002 (Female) *[Clinical finding]* it falls under SNOMED-CT Concept ID: 429019009 (Finding related to biological sex) *[Clinical finding]* and therefore isn't the appropriate hierarchy given the aspect of self-identification.
GAP? (443390004)	Is this a Gap? SNOMED-CT Concept ID: 443390004 (Refused) [Qualifier value] is closest concept. Alternative: HL7 V3 Code System NullFlavor [2.16.840.1.113883.5.1008] Code System Code: ASKU ASKU definition doesn't distinguish between: Subject knows, but declined to answer, and Subject doesn't know the answer. "Information was sought but not found (e.g., client was asked but didn't know) it"

1.6.15 ImmunizationCode

This value set contains the list of codes used to represent an immunization and uses a value set developed and maintained by the CDC's National Center of Immunization and Respiratory Diseases (NCIRD), the HL7 Table 0396 code set, Vaccine Administered (CVX) OID: 2.16.840.1.113883.12.292

See: http://www2a.cdc.gov/vaccines/iis/iisstandards/vaccines.asp?rpt=cvx

See also: CDC HL7 Table 0227, Manufacturers of Vaccines (MVX)
OID [2.16.840.1.114222.4.11.826]

http://www2a.cdc.gov/vaccines/iis/iisstandards/vaccines.asp?rpt=mvx

1.6.16 IncomeSource

This value set is used to represent the source of a client's income within the past 30 days. These concepts were drawn from "Final HMIS Data Standards March 2010" (Homeless Management Information System) associated with field 4.1 Income and Sources.

See:
https://www.onecpd.info/resources/documents/FinalHMISDataStandards_March2010.pdf

Recommendation:

Code System: SNOMED-CT [2.16.840.1.113883.6.96]

Add missing values under SNOMED-CT 365552003 (income details) [clinical finding]

Data Element	Definition
earnedIncome	Earned Income (i.e., employment income)
unemploymentInsurance	Unemployment Insurance
supplementalSecurityIncome	Supplemental Security Income (SSI)
socialSecurityDisabilityIncome	Social Security Disability Income (SSDI)
disabilityPaymentVA	Veteran's disability payment
disabilityInsurance	Private disability insurance
workersComp	Worker's compensation
temporaryAssistanceNeedyFamilies	Temporary Assistance for Needy Families (TANF) (or local program name)
generalAssistance	General Assistance (GA) (or local program name)

Data Element	Definition
retirementIncomeSSI	Retirement income from Social Security
pensionVA	Veteran's pension
childSupport	Child support
alimony	Alimony or other spousal support

1.6.17 LanguageAbilityMode

This value set is used to represent the client's ability with language.

Recommendation:

Code System(s): LanguageAbilityMode [2.16.840.1.113883.5.60]

Value Set: HL7 LanguageAbilityMode [2.16.840.1.113883.1.11.12249] DYNAMIC

Data Element	Definition
ESGN (Expressed signed)	Expressed signed
ESP (Expressed spoken)	Expressed spoken
EWR (Expressed written)	Expressed written
RSGN (Received signed)	Received signed
RSP (Received spoken)	Received spoken
RWR (Received written)	Received written

1.6.18 LanguageAbilityProficiency

This value set is used to represent the client's proficiency with language.

Recommendation:

Code System(s): LanguageAbilityProficiency [2.16.840.1.113883.5.61]

Value Set: LanguageAbilityProficiency [2.16.840.1.113883.1.11.12199] DYNAMIC

Data Element	Definition
G (Good)	Good
P (Poor)	Poor
E (Excellent)	Excellent
F (Fair)	Fair

1.6.19 MaritalStatus

Recommendation:

Code System: MaritalStatus: [2.16.840.1.113883.5.2]
Value Set: HL7 Marital Status 2.16.840.1.113883.1.11.12212 DYNAMIC

Data Element	Definition
S (Never Married/Single)	**HL7 V3 Marital Status Value Set:** Never Married
M (Married)	**HL7 V3 Marital Status Value Set:** Married
A (Annulled)	**HL7 V3 Marital Status Value Set:** Annulled
D (Divorced)	**HL7 V3 Marital Status Value Set:** Divorced
L (Legally Separated)	**HL7 V3 Marital Status Value Set:** Legally Separated
T (Domestic Partner)	**HL7 V3 Marital Status Value Set:** Domestic Partner
I (Interlocutory)	**HL7 V3 Marital Status Value Set:** Interlocutory (Interlocutory decrees were most commonly used in divorce actions, in which the terms of the divorce were stated in an interlocutory decree, which would be in force until a final decree could be granted after a period of time (such as one year after serving the divorce petition). Interlocutory decrees of divorce have been abandoned as a procedure in most states, because they seldom had the desired effect and appeared to waste the parties' time.
P (Polygamous)	**HL7 V3 Marital Status Value Set:** Polygamous
W (Widowed)	**HL7 V3 Marital Status Value Set:** Widowed

1.6.20 OMHDisabilityStatus

This value set is used to convey information related to the level of disability for a Behavioral Health client and reflects the questions presented in the Office of Minority Health (OMH) Data Standard for Disability Status.

Recommendation:

Encode OMH questions in LOINC. Answers to questions are Yes/No.

In the event more precise details are desired in response to each question, values for response could be drawn from the SNOMED-CT [clinical finding] hierarchy.

Code Systems:

Question: LOINC [2.16.840.1.113883.6.1]

If encoded: Answer: SNOMED-CT [2.16.840.1.113883.6.96]

Data Element	Definition
CognitiveDisability	Question 3: Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions? (5 years old or older)
HearingDisability	Question 1: Are you deaf or do you have serious difficulty hearing?
OtherADLDisability	Question 6: Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)
PersonalCareDisability	Question 5: Do you have difficulty dressing or bathing? (5 years old or older)
VisualDisability	Question 2: Are you blind or do you have serious difficulty seeing, even when wearing glasses?
WalkingDisability	Question 4: Do you have serious difficulty walking or climbing stairs? (5 years old or older)

1.6.21 OMHEthnicityCodeValueSet

This value set contains the Office of Minority Health ethnicity codes used to describe the client. It reflects field 17 in the Arizona Department of Health Services Demographic and Outcomes Data Set User Guide (DUG) v.6 and is used to distinguish whether or not the client is Hispanic. Race and ethnicity are considered separate and distinct identities, with Hispanic or Latino origin asked as a separate question. This value set has been expanded to include all values defined in the OMH Data Standards for Race and Ethnicity.

Recommendation:

PHINVADS Reference:

- Code System: PH_RaceAndEthnicity_CDC (Race & Ethnicity – CDC) *[2.16.840.1.113883.6.238]*
- Value Set Code: PHVS_EthnicityGroup_CDC
- Value Set Name: Ethnicity group
- Value Set OID: *[2.16.840.1.114222.4.11.837]*

Rationale:

- Referenced in HITSP C80
- Maps to OMH Ethnicity Standard and OMH Race Standard cited in Meaningful Use final rule §170.207 (f) Race and Ethnicity standard. OMB Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, Oct 30, 1997

Data Element	Definition
2135-2	This code is used to indicate a client who self-identifies as Hispanic or Latino. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Ethnicity_CDC Value Set Name: Detailed Ethnicity Concept Code: 2135-2 (Hispanic or Latino)
2148-5	This code is used to indicate a client who self-identifies as Mexican. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Ethnicity_CDC Value Set Name: Detailed Ethnicity Concept Code: 2148-5 (Mexican) This value maps to OMH Ethnicity data standard question (b) Yes, Mexican, Mexican American, Chicano/a and rolls up to the Hispanic or Latino category of the OMB standard.
2149-3	This code is used to indicate a client who self-identifies as Mexican American. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Ethnicity_CDC Value Set Name: Detailed Ethnicity Concept Code: 2149-3 (Mexican American) This value maps to OMH Ethnicity data standard question (b) Yes, Mexican, Mexican American, Chicano/a and rolls up to the Hispanic or Latino category of the OMB standard.
2151-9	This code is used to indicate a client who self-identifies as Chicano or Chicana. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Ethnicity_CDC Value Set Name: Detailed Ethnicity Concept Code: 2151-9 (Chicano) This value maps to OMH Ethnicity data standard question (b) Yes, Mexican, Mexican American, Chicano/a and rolls up to the Hispanic or Latino category of the OMB

Data Element	Definition
	standard.
2180-8	This code is used to indicate a client who self-identifies as Puerto Rican. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Ethnicity_CDC Value Set Name: Detailed Ethnicity Concept Code: 2180-8 Puerto Rican This value maps to OMH Ethnicity data standard question (c) Yes, Puerto Rican and rolls up to the Hispanic or Latino category of the OMB standard.
2182-4	This code is used to indicate a client who self-identifies as Cuban. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Ethnicity_CDC Value Set Name: Detailed Ethnicity Concept Code: 2182-4 (Cuban) This value maps to OMH Ethnicity data standard question (d) Yes, Cuban and rolls up to the Hispanic or Latino category of the OMB standard.
2186-5	This code is used to indicate a client who does not identify as Hispanic or Latino. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_EthnicityGroup_CDC Value Set Name: Ethnicity Group Concept Code: 2186-5 (Not Hispanic or Latino) This value maps to OMH Ethnicity data standard question (a) No, not of Hispanic, Latino/a, or Spanish origin and rolls up to the Hispanic or Latino category of the OMB standard.

1.6.22 OMHRaceCodeValueSet

The OMHRaceCodeValueSet value set contains the Office of Minority Health race codes used to describe a client. It reflects fields 12-16 in the Arizona Department of Health Services Demographic and Outcomes Data Set User Guide (DUG) v.6 and describes the general race category reported by the client. The client may report more than one race.

Race and ethnicity are considered separate and distinct identities, with Hispanic or Latino origin asked as a separate question. This value set has been expanded to include all values defined in the Office of Minority Health (OMH) data standards for Race.

Recommendation:

PHINVADS Reference:

- Code System: PH_RaceAndEthnicity_CDC (Race & Ethnicity – CDC) *[2.16.840.1.113883.6.238]*
- Value Set Code: PHVS_RaceCategory_CDC
- Value Set Name: Race Category
- Value Set OID: *[2.16.840.1.114222.4.11.836]*

Rationale:

- Referenced in HITSP C80
- Maps to OMH Ethnicity Standard and OMH Race Standard cited in Meaningful Use final rule §170.207 (f) Race and Ethnicity standard. OMB Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, Oct 30, 1997

Data Element	Definition
1002-5	This code is used to indicate a client having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 1002-5 (American Indian or Alaska Native) This value maps to OMH Race data standard question (c) American Indian or Alaska Native and is part of the current OMB standard.
2028-9	This code is used to indicate a client having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2028-9 (Asian) This value maps to OMH Race data standard question (j) Other Asian in OMH Race codes. This value rolls up to the Asian category of the OMB standard.
2029-7	This code is used to indicate a client who self-identifies as an Asian Indian. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2029-7 (Asian Indian) This value maps to OMH Race data standard question (d) Asian Indian and rolls up to the Asian category of the OMB standard.
2034-7	This code is used to indicate a client who self-identifies as Chinese. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC

Data Element	Definition
	Value Set Name: Detailed Race Concept Code: 2034-7 (Chinese) This value maps to OMH Race data standard question (e) and rolls up to the Asian category of the OMB standard.
2036-2	This code is used to indicate a client who self-identifies as Filipino. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2036-2 (Filipino) This value maps to OMH Race data standard question (f) and rolls up to the Asian category of the OMB standard.
2039-6	This code is used to indicate a client who self-identifies as Japanese. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2039-6 (Japanese) This value maps to OMH Race data standard question (g) and rolls up to the Asian category of the OMB standard.
2040-4	This code is used to indicate a client who self-identifies as Korean. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2040-4 (Korean) This value maps to OMH Race data standard question (h) and rolls up to the Asian category of the OMB standard.
2047-9	This code is used to indicate a client who self-identifies as Vietnamese. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2047-9 (Vietnamese) This value maps to OMH Race data standard question (i) and rolls up to the Asian category of the OMB standard.
2054-5	This code is used to indicate a client having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.” Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2054-5 (Black or African American) This value maps to OMH Race data standard question (b) Black or African American and is part of the current OMB standard.
2076-8	This code is used to indicate a client having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_RaceCategory_CDC Value Set Name: Race Category Concept Code: 2076-8 (Native Hawaiian or Other Pacific Islander)

Data Element	Definition
	This value is included in the minimum race and ethnicity categories defined by the U.S. Office of Management and Budget (OMB).
2079-2	This code is used to indicate a native Hawaiian client. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2079-2 (Native Hawaiian) This value maps to OMH Race data standard question (k) Native Hawaiian and rolls up to the Native Hawaiian or Other Pacific Islander category of the OMB standard.
2080-0	This value is used to indicate a client who self-identifies as Samoan. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2080-0 (Samoan) This value maps to OMH Race selection (m) and rolls up to the Native Hawaiian or Other Pacific Islander category of the OMB standard.
2086-7	This value is used to indicate a client who self-identifies as Guamanian or Chamorro. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2086-7 (Guamanian or Chamorro) This value maps to OMH Race selection (l) and rolls up to the Native Hawaiian or Other Pacific Islander category of the OMB standard.
2106-3	This code is used to indicate a client having origins in any of the original peoples of Europe, the Middle East, or North Africa. Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2106-3 (White) This value OMH Race data standard question (a) and is part of the current OMB standard.
2131-1	Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_RaceCategory_CDC Value Set Name: Race Category Concept Code: 2131-1 (Other race)
2500-7	This value is used to indicate a client who self-identifies as Other Pacific Islander Code System Name: Race & Ethnicity - CDC Value Set Code: PHVS_Race_CDC Value Set Name: Detailed Race Concept Code: 2500-7 (Other Pacific Islander) This value maps to OMH Race selection (n) and rolls up to the Native Hawaiian or Other Pacific Islander category of the OMB standard.

1.6.23 PreferredLanguage (ISO 639-2)

The PreferredLanguage (ISO 639-2) value set contains the standards-based language codes used to represent a clients preferred or secondary languages.

Recommendation:

Per July 2012 Consolidated CDA Implementation Guide (C-CDA):

Code System: Internet Society Language [2.16.840.1.113883.1.11.11526]

Value Set: Language [2.16.840.1.113883.1.11.11526] DYNAMIC

Alternative:

Per Meaningful Use Stage 2 requirements:

ISO 639-2 constrained to values contained in ISO 639-1 (active languages) for the client's Preferred Language ISO 639-1 [1.0.639.1]

- Value Set Code: PHVS_Language_ISO_639-2_Alpha3
- Value Set Name: Language (Primary language spoken)
- Value Set OID: [2.16.840.1.114222.4.11.831]

Data Element	Definition
eng (English)	**ISO-639-2:** eng **ISO 639-1:** en (English)
Spa (Spanish; Castilian)	**ISO 639-2:** spa (Spanish; Castilian) **ISO-639-1:** es
chi (Chinese)	**ISO 639-2:** chi **ISO-639-1:** zh
nor (Norwegian)	**ISO 639-2:** nor **ISO-639-1:** no

1.6.24 PregnancyPuerperium

This value set is used to describe the pregnancy or post-partum status of female clients in treatment.

This value set could be expanded to include all values under the following SNOMED-CT hierarchies:

- 118185001 (finding related to pregnancy) [Clinical finding]
- 118213005 (postpartum finding) [Clinical finding]

Data Element	Definition
Patient currently pregnant	SNOMED-CT Concept ID: 77386006 (patient currently pregnant) [clinical finding]
Postpartum finding	SNOMED-CT Concept ID: 118213005 (Postpartum finding) [clinical finding]

1.6.25 PrimaryResidence

This value set is used to specify the place where the client has spent most of his/her time in the past 30 days prior to intake or any change thereafter.

Recommendation:

Code System: SNOMED-CT [2.16.840.1.113883.6.96]

Add GAPs under SNOMED-CT 365508006 (Residence and accommodation circumstances – finding) [Clinical finding]

Data Element	Definition
IndependentLiving	Independent living: Client lives in a private residence with or without support in activities of daily living. Living arrangement may be with a roommate, housemate, and spouse or by self. Use only with individuals 15 years or older.
BoardingHome	Boarding Home: An unlicensed residence that provides no behavioral health services but includes room and board.
SupervisoryCareAssisted living	Supervisory care/assisted living: A facility licensed by state Assisted Living licensure. Use only with individuals 18 years or older.
State Hospital	A publicly funded inpatient facility for clients with mental illness. Use only with individuals 18 years or older.
Jail/Correctional facility	When an individual resides in a jail and/or correctional facility with care provided 24 hours, 7 days a week basis. This includes jail, correctional facility, prison, youth authority facility, juvenile hall, boot camp or Boys Ranch.
HomelessHomelessShelter	Homeless/homeless shelter: A client is considered homeless if he/she lacks a fixed, regular and adequate nighttime residence and/or his/her primary nighttime residence is either of the following: (1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations; (2) an institution

Data Element	Definition
	that provides a temporary residence for individuals intended to be institutionalized; or (3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street).
FosterHome	Foster Home: When a client lives in a home other than that of the client's family. This includes therapeutic foster care facilities/home.
NursingHome	Nursing Home: An establishment that provides living quarters and care for the elderly and the chronically ill.
HomeWithFamily	Home with family: When a client lives with parents, relatives, adopted family, or legal guardian.
Level123TreatmentSetting	Level 1, 2, 3 Treatment Settings: Level facilities provide a structured treatment setting with daily 24-hour supervision and an intensive treatment program, including medical support services. Level 1 facility includes the following subcategories: (a) hospitals; (b) sub-acute facilities; and (c) residential treatment centers. Level 2 Behavioral Health Residential facilities provide structured treatment setting with 24-hour supervision and counseling or other therapeutic activities for clients who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional. Level 3 Behavioral Health Residential facilities provide continuous 24-hour supervision and treatment in a group residential setting to clients who are determined to be capable of independent functioning but still need some protective oversight to insure they receive needed services.
TransitionalHousingLevelIV	Transitional housing (Level IV) or DES group homes for children refer to a shelter/housing arrangement for short-term care. This includes DES children group homes, half-way/three-quarter way house, rural substance abuse transitional center, and all others not included in Levels I, 2, and 3 treatment settings.
PermanentHousingForFormerlyHomelessPersons	Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)
PsychiatricHospital	Psychiatric hospital or other psychiatric facility
SATreatmentFacility	Substance abuse treatment facility or detox center
HospitalNonPsychiatric	Hospital (non-psychiatric)
HotelMotelSelfPay	Hotel or motel paid for without emergency shelter voucher
HomeWithFriends	Staying or living in a friend's room, apartment or house
PlaceNotMeantForHabitation	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside); inclusive of "non-housing service site (outreach programs only)"
SafeHaven	Safe Haven
RentalVASH	Rental by client, with Veterans Affairs Supportive Housing (VASH) housing subsidy.

Data Element	Definition
RentalNonVASH	Rental by client, with other (non-VASH) ongoing housing subsidy. (Veterans Affairs Supportive Housing (VASH))
OwnHomeHousingSubsidyOngoing	Owned by client, with ongoing housing subsidy:
RentalNoHousingSubsidyOngoing	Rental by client, no ongoing housing subsidy

1.6.26 ReferralSource

This value set describes the source of referral for this client for this episode of care.

Recommendation:

National Uniform Billing Committee (NUBC) CURRENT UB DATA SPECIFICATIONS MANUAL) UB-04
FL 15 – Admit Source (HITSP-FL-15)

Code System: NUBC UB-04 Manual OID [2.16.840.1.113883.6.301]
Value Set: NUBC Admission Source OID [2.16.840.1.113883.6.301.4]

If this is determined to be the appropriate code system, there are missing values.

Data Element	Definition
1 (Friend)	**Non-Health Care - Patient admitted to facility** The patient presents to this facility with an order from a physician for services or seeks scheduled services for which an order is not required (e.g., mammography). This includes non-emergent self-referrals.
1 (Family)	**Non-Health Care - Patient admitted to facility** The patient presents to this facility with an order from a physician for services or seeks scheduled services for which an order is not required (e.g., mammography). This includes non-emergent self-referrals.
1 (Self)	**Non-Health Care - Patient admitted to facility** The patient presents to this facility with an order from a physician for services or seeks scheduled services for which an order is not required (e.g., mammography). This includes non-emergent self-referrals.
2 (Community agency)	**Clinic Referral** The patient was referred to this facility for outpatient or referenced diagnostic services.
2 (Other Behavioral Health Provider)	**Clinic Referral** The patient was referred to this facility for outpatient or referenced diagnostic services.
6 (Federal Agency)	**Transfer From Another Health Care Facility** The patient was referred to this facility for services by (a physician of) another health care facility not defined elsewhere in this code list where he or she was an

Data Element	Definition
	inpatient or outpatient.
8 (Criminal Justice System)	**Court/Law Enforcement** The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services. This includes transfers from incarceration facilities.
8 (Child Protective Service Urgent Response)	**Court/Law Enforcement** The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services. This includes transfers from incarceration facilities.
9 (Other)	**Information Not Available** The means by which the patient was referred to this hospital's outpatient department is not known.
D (Health Plan)	**Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer** The patient received outpatient services in this facility as a transfer from within this hospital resulting in a separate claim to the payer. For purposes of this code, "Distinct Unit" is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could include observation service, psychiatric units, rehabilitation units, a unit in a critic al access hospital, or a swing bed located in an acute hospital. (Clarification has been added that this code should be used only when a separate claim to the payer will result and that the code is applicable to outpatients also.)

1.6.27 ReligiousAffiliation

A value set of codes that reflect spiritual faith affiliation.

Value Set: HL7 Religious Affiliation 2.16.840.1.113883.1.11.19185 DYNAMIC

1.6.28 SexualOrientation

This value set specifies the sexual orientation of a client. (For Age 18 and older) It refers to an enduring pattern, or lack thereof, of a romantic, sexual, and/or emotional attraction to men, women, or all genders.

Recommendation

- Add missing values under SNOMED-CT: 118200004 (finding related to sexual state) [Clinical finding] sub-hierarchy

Data Element	Definition
20430005	Heterosexual: a person who is romantically, sexually, and/or emotionally attracted to persons of the opposite gender/gender identity. SNOMED-CT Concept ID: 20430005 (Heterosexual) *[Clinical finding]*
385432009	Not Applicable Due to Age: Ages 0 thru 17 GAP?

Data Element	Definition
	SNOMED-CT Concept ID: 385432009 (Not applicable) *[Qualifier value]* closest concept, but does not take age into consideration. **Alternative:** HL7 V3 Code System NullFlavor *[2.16.840.1.113883.5.1008]* Code System Code: NA
42035005	Bisexual: a person who is romantically, sexually, and/or emotionally attracted to men, women, or all genders/gender identities. SNOMED-CT Concept ID: 42035005 (Bisexual) *[Clinical finding]*
443390004	Decline to Answer: a person who did not answer the question; or a person who declined to answer the question. SNOMED-CT Concept ID: 443390004 (Refused) *[Qualifier value]* **Alternative:** HL7 V3 Code System NullFlavor *[2.16.840.1.113883.5.1008]* Code System Code: ASKU ASKU definition doesn't distinguish between: Subject knows, but declined to answer, and Subject doesn't know the answer. "Information was sought but not found (e.g., client was asked but didn't know) it"
76102007	Gay: a man who is romantically, sexually, and/or emotionally attracted to persons of the same gender/gender identity. SNOMED-CT Concept ID: 76102007 (male homosexual) *[Clinical finding]* Comment: GAY is a synonym for Concept ID: 38628009 (Homosexual) *[Clinical finding]* Concept ID: 76102007 (Male homosexual) is a subset of Concept ID: 38628009 (Homosexual) *[Clinical finding]* sub- hierarchy
89217008	Lesbian: a woman who is romantically, sexually, and/or emotionally attracted to persons of the same gender/gender identity. SNOMED-CT Concept ID: 89217008 (Lesbian) *[Clinical finding]*
GAP (Asexual)	This is a GAP. Asexual: a person who is not romantically, sexually, and/or emotionally attracted to persons of any gender. This is a gap, since there isn't a SNOMED-CT concept that fits the definition of asexual. However the following are the closest concepts that could be found and the work group suggested that they be presented for feedback in the next ballot iteration. • SNOMED-CT Concept ID: 47037006 (not sexually active) *[Clinical finding]* • SNOMED-CT Concept ID: 24594008 (never sexually active) *[Clinical finding]*. This concept falls below SNOMED-CT Concept ID: 47037006 (not sexually active) *[Clinical finding]*
GAP (Questioning)	This is a GAP. Questioning: a person who is questioning his or her sexual orientation.

Data Element	Definition
	Is this a gap? Potential values include: • SNOMED-CT Concept ID: 87991007 (Gender identity disorder) *[Clinical finding]* • SNOMED-CT Concept ID: 93461009 (Gender dysphoria) *[Clinical finding]* Is SNOMED-CT Concept ID: 87991007 (Gender identity disorder) *[Clinical finding]* the correct sub-hierarchy under which to place the Questioning concept? • Gender identity disorder (GID) is a formal diagnosis used by psychologists and physicians to describe persons who experience significant gender dysphoria (discontent with their biological sex and/or the gender they were assigned at birth). See Gender dysphoria in Wikipedia
GAP? (Not Applicable)	Is this a GAP (due to age condition)? Not Applicable Due to Age: Ages 0 thru 17 SNOMED-CT Concept ID: 385432009 (Not applicable) *[Qualifier value]* is the closest concept, but concept does not take age into consideration. **Alternative:** HL7 V3 Code System NullFlavor *[2.16.840.1.113883.5.1008]* Code System Code: NA

1.6.29 SubstanceOfAbuse

This value set identifies an example set of commonly referenced/reported psychoactive substances that may be abused by a person who is participating in and receiving behavioral health services.

The following categories of substances are associated with use, dependence and abuse. These high-level categories can be more granularly expressed once consensus has been achieved on the level of granularity that should be represented in this value set. (This may be related to the code systems used to represent these values.)

Related concepts:

SNOMED-CT: 312417001 (substance of abuse) [substance]

Data Element	Definition
53527002	Alcohol SNOMED-CT: 53527002 (alcoholic beverage) [substance]
387085005	Cocaine/Crack (CNS Stimulants) SNOMED-CT: 387085005 (cocaine) [substance]

Data Element	Definition
398705004	Marijuana/Hashish SNOMED-CT: 398705004 (Cannabis) [substance]
387341002	Heroin/Morphine (Opiates/Narcotics) SNOMED-CT: 387341002 (heroin) [substance]
404642006	Other Opiates/Synthetics SNOMED-CT: 404642006 (opiate agonist) [substance]
387499002	Methamphetamine/Speed (CNS Stimulants SNOMED-CT: 387499002 (methamphetamine) [substance]
264301008	Hallucinogens SNOMED-CT: 264301008 (psychoactive substance of abuse - non-pharmaceutical) [substance]
373333006	Other Stimulants SNOMED-CT: 373333006 (stimulant) [substance]
372664007	Benzodiazepines (CNS Depressants) SNOMED-CT: 372664007 (benzodiazepine) [substance]
Inhalants	Inhalants SNOMED-CT: GAP
419937006	Sedatives/Tranquilizers (CNS Depressants) SNOMED-CT: 419937006 (psychotherapeutic agent) [substance]
Other Drugs	Other Drugs

1.6.30 TobaccoUseExposure

This list will contain all values descending from the SNOMED CT 365980008 tobacco use and exposure - finding hierarchy as referenced in Meaningful Use and Consolidated CDA.

Data Element	Definition
81703003	Chews tobacco - SNOMED-CT 81703003 [clinical finding]
228494002	Snuff user - SNOMED-CT 228494002 [clinical finding]
59978006	Cigar smoker - SNOMED-CT 59978006 [clinical finding]
43381005	Passive smoker - SNOMED-CT 43381005 [clinical finding]

Data Element	Definition
230063004	Heavy cigarette smoker - SNOMED CT 230063004 [clinical finding]
8392000	Non-Smoker - SNOMED CT 8392000 [clinical finding]
56578002	Moderate smoker (20 or less per day) SNOMED-CT Concept ID: 56578002
82302008	Pipe smoker - SNOMED-CT Concept ID: 82302008 [clinical finding]
8517006	Ex-smoker - SNOMED-CT ID: 8517006 [clinical finding]

1.6.31 TreatmentParticipation

The TreatmentParticipationCode value set specifies the method or reason used to ensure the client's participation in a behavioral health program. This value set was renamed from ParticipationCode to clarify its purpose and to distinguish it from the HL7 reserved term, "Participation".

Recommendation

- Code System: SNOMED-CT OID: [2.16.840.1.113883.6.96]
- Add missing concepts under the SNOMED-CT hierarchy: 397688009 (finding related to participation with treatment) *[clinical finding]*

Data Element	Definition
Involuntary Participation in Behavioral Health Treatment based on Criminal Judgment	**GAP**
Voluntary	Voluntary participation in Behavioral Health treatment. **GAP**
Involuntary Participation in Behavioral Health Treatment due to Civil Judgment	**GAP**

1.6.32 TreatmentService

The TreatmentService value set is used to describe the type of treatment service provided to Behavioral Health clients. At least one treatment service must be selected at time of Intake (admission) and at discharge.

Example values are drawn from the CSAT GPRA Client Outcome Measures for Discretionary Programs Codebook.

Data Element	Definition
Screening	Screening
BriefIntervention	Brief Intervention
BriefTreatment	Brief Treatment
ReferralToTreatment	Referral to Treatment
TreatmentRecoveryPlanning	Treatment/Recovery Planning
IndividualCounseling	Individual Counseling
GroupCounseling	Group Counseling
FamilyAndMarriageCounseling	Family/Marriage Counseling
CoOccurringTreatmentRecoveryServices	Co-Occurring Treatment/Recovery Services
PharmacologicalInterventions	Pharmacological Interventions
HIVAIDSCounseling	HIV/AIDS Counseling