HL7
Meaningful Use Stage 2
Ambassador Briefing

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Topics

- What is Meaningful Use
- Quick Review of Meaningful Use Stage 1
- Changes in Stage 2
- Beyond Stage 2…

What is Meaningful Use?

- US Federal Regulation Incenting Providers to use EHRs
- Includes requirements for what providers do with EHRs
- And requirements for EHR products
  - Functionality
  - Standards
  - Security
- Certification

Meaningful Use Standards in Stage 1

- HL7 Continuity of Care Document or CCR
  - Patient Summaries
    - SNOMED CT or ICD-9-CM for problems
    - LOINC if reported for lab results
    - CPT-4 or ICD-9-CM for procedures
- HL7 Version 2.3.1 or 2.5.1
  - Laboratory Reporting to Public Health
  - Immunization Reporting to Public Health
  - Disease Surveillance

Implementation Guides in Stage 1

- Patient Summaries
  - HITSP C32 Version 2.5
- CDC Immunization Guides (2.3.1 and 2.5.1)
- Electronic Laboratory Reporting to Public Health, Release 1
  - No MU recognized guide for 2.3.1
- Disease Surveillance
  - PHIN Guide selected but then withdrawn

Final Standards for Stage 2

- CDA Consolidation Guide replaces CCD 1.0 & CCR
  - Updates CCD to Version 1.1
  - Adds Consult Note, H&P, Discharge Summary, Progress Note, Procedure Note, and Operative Note
- CCR and CCD Retained for VIEW
- Vocabulary Updates
  - SNOMED CT® for Problems
  - ICD-10-CM for Diagnoses
  - LOINC® for Labs
  - CPT-4/HCPCS or ICD-10-PCS for Procedures
  - RX-Norm for eRX
  - ISO 639-~~1~~2 for Preferred Language
  - OMB Guidelines for Race & Ethnicity
  - SNOMED CT Value Set for Smoking Status

Final Standards for Stage 2

- HL7 Version 2.5.1 for Communication to Public Health (dropped 2.3.1 options)
  - CDC Immunization Guide (2.5.1)
  - HL7 ELR Guide (2.5.1)
  - PHIN Guide for Surveillance (2.5.1) (Inpatient Only)
- HL7 2.5.1 and LOINC for Laboratory Reporting
- HL7 CDA for Cancer Reporting (Optional)
- HL7 Infobutton and URL/SOA Guides for
  - Patient Education
  - Provider Reference Content
- HL7 QRDA I and III for Quality Reporting

Patient Engagement instead of Exchange

- New Standards for Transport
  - The Direct Protocol
  - IHE XDM and XDR (optional)
  - NwHIN Exchange Standards (optional)
- View, Download and Transmit for Patients
- Summary of Care Exchange for Transitions

Clinical Decision Support

Enable Clinical Decision Support

- Reference to Evidence
  - Publications, Authors, Funding Sources
- Interventions vs. Rules
- Tied to 4 Clinical Quality Measures

Support Reference Content Access on:

- Problems, Medications, Allergies
- Demographics, Labs and Vital Signs

Consolidated CDA Clinical Documents

Harmonizes HITSP C32, IHE, HL7 Specifications

- **Continuity of Care Document 1.1**
- **History and Physical**
- **Consult Note**
- **Discharge Summary**
- **Procedure Note**
- **Progress Note**
- **Diagnostic Imaging Report**
- **Operative Note**
- ~~**Unstructured Document**~~

Cancer Reporting

Based on IHE PCC Technical Framework

Same basis as HITSP C32

- Cancer Diagnosis
- Social History
- Problems
- Results
- Procedures
- Medications
- Care Plan
- Radiation Oncology

Beyond Stage 2 …

- Public Health Case Reporting using CDA
- Laboratory Ordering
- eMeasures (HQMF)
- CDA for Claims Attachments (esMD)

Using CCDA in Meaningful Use

- Common MU Data Set
- CCDA Sections and Entries
- Other Data Sets
  - View
  - Create
  - Transfers of Care

CCDA Mapping to Common MU Data Set

Data Element	Vocabulary	CCDA Section	Entry
1) Patient name.		recordTarget/patientRole/patient/	name
2) Sex.		recordTarget/patientRole/patient/	administrativeGenderCode
3) Date of birth.		recordTarget/patientRole/patient/	birthTime
4) Race	OMB Race and Ethnicity	recordTarget/patientRole/patient/	raceCode sdtc:raceCode
5) Ethnicity	OMB Race and Ethnicity	recordTarget/patientRole/patient/	ethnicGroupCode
6) Preferred language	**ISO 639-2**	recordTarget/patientRole/patient/	**languageCommunication/languageCode**
7) Smoking status	**SNOMED CT (See value Set)**	Social History Section	**Smoking Status Observation**
8) Problems	SNOMED CT	Problem Section	Problem Concern Act Problem Observation
9) Medications	RxNorm	Medication Section	Medication Activity Act
10) Medication allergies	RxNorm	Allergies Section	Allergy
11) Laboratory test(s)	LOINC	Results Section	Results Organizer
12) Laboratory result(s)		Results Section	Results Entry
13) Vital signs		Vital Signs Section	Vital Sign Entry
14) Care plan field(s)		Care Plan Section	Care Plan Entries
15) Procedures	**SNOMED CT** or HCPCS/CPT-4 CDT (optional) ICD-10-PCS (optional)	Procedures Section	Procedures Activity Act, Observation or Procedure
16) Care Team Member(s)		documentationOf/serviceEvent componentOf/encompassingEncoun	performer

Additional Data Elements in MU

The provider's name and office contact information;	documentationOf/serviceEvent componentOf/encompassingEncounter	 performer
date and location of visit;	componentOf/encompassingEncounter	effectiveTime location/serviceProviderOrganization
reason for visit;	Reason for Visit Section or Chief Complaint and Reason for Visit Section	
immunizations and/or medications administered during the visit;	Medications Section Immunizations Section	 Medication Activity Act Immunization Activity
diagnostic tests pending;	Results Section	Results Organizer
clinical instructions;	(any) Care Plan Section	Instructions
future appointments;	(any) Care Plan Section	Plan of Care Activity Encounter
referrals to other providers;	(any) Care Plan Section	Plan of Care Activity Encounter
future scheduled tests;	(any) Care Plan Section	Plan of Care Activity Observation
and recommended patient decision aids.	(any) Care Plan Section	 Instructions
Admission and discharge dates and locations;	componentOf/encompassingEncounter	effectiveTime location/serviceProviderOrganization
discharge instructions;	(any) Care Plan Section	Instructions
and reason(s) for hospitalization.	Chief Complaint Section Reason for Visit Section Chief Complaint and Reason for Visit Hospital Admission Diagnosis Hospital Discharge Diagnosis	

More Data Elements

(i) Encounter diagnoses.	SNOMED CT or ICD-10-CM	Assessment and Plan Section	Encounter Diagnosis
(ii) Immunizations	CVX	Immunizations Section	
(iii) Cognitive status;		Functional Status Section	Cognitive Status Result Organizer
(iv) Functional status; and		Functional Status Section	Functional Status Result Organizer
(v) Ambulatory setting only. The reason for referral;		Reason for Referral Section	
and referring or transitioning provider's name and office contact information.		componentOf/encompassingEncounter	
(vi) Inpatient setting only. Discharge instructions.		Plan of Care Section	

Additional Resources

- **All of my blog posts on MU2:**

  http://bit.ly/MGonMU2

Questions