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  - PHIN Guide selected but then withdrawn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® 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

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

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

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

- All of my blog posts on MU2:
Questions