Conformance Reporting User Guide

v6 | September 21, 2022

Conformance Reporting User Guide

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Introduction

Conformance standards or adherence to certain specifications, standards, and guidelines, are designed to continually improve the data that flows through the Michigan Health Information Network Shared Services (MiHIN), ensuring it is complete and actionable when it's received by the practitioners using the information. Conformance thresholds apply to all inpatient, observation, and ED visits.

Hospitals must maintain data quality standards for all ADT and C-CDA transmission. ADT messages must meet and maintain the associated conformance threshold across three categories: complete routing, complete mapping, and adherence to coding standards. C-CDA data conformance is met when all med rec fields have been completely routed.

The overall purpose of the Conformance Module is to have automated conformance reporting available for ADTs and CCDs to the customer at any time. It serves two primary functions:

1. To display the Conformance Report of that user's organization in a convenient way.

   ***Note**: these reports do not contain PHI and are instead aggregated evaluations on various fields or segments within messages in general.*

1. To allow the user to view and download live production messages of the message type in question (ADTs or C-CDAs), which serve as examples of why that organization's conformance scores were compliant or not. These are live messages that do contain PHI, but are limited to messages that were sent by, and originated from, the organization whose user is logged in. These are referred to as "fallout examples."

In order to utilize the full capabilities of the conformance reporting, the user must first get a MIGateway account provisioned and have the Conformance Module activated. The user may then interact with the functionality within the module, including viewing the general reports and being able to search for, view, and download specific message examples.

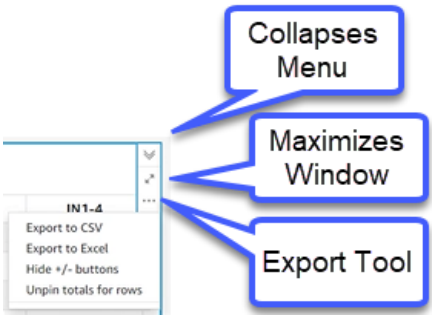
How to use this guide

This guide will help you and your organization navigate the Conformance Reporting Module within the MIGateway platform. Use this guide to achieve the full capabilities the Conformance Reporting module offers.

Note: *The reports in this guide and their data in the Conformance Reporting Module will vary based on your specific user's Conformance Reporting permissions*

Document Conventions

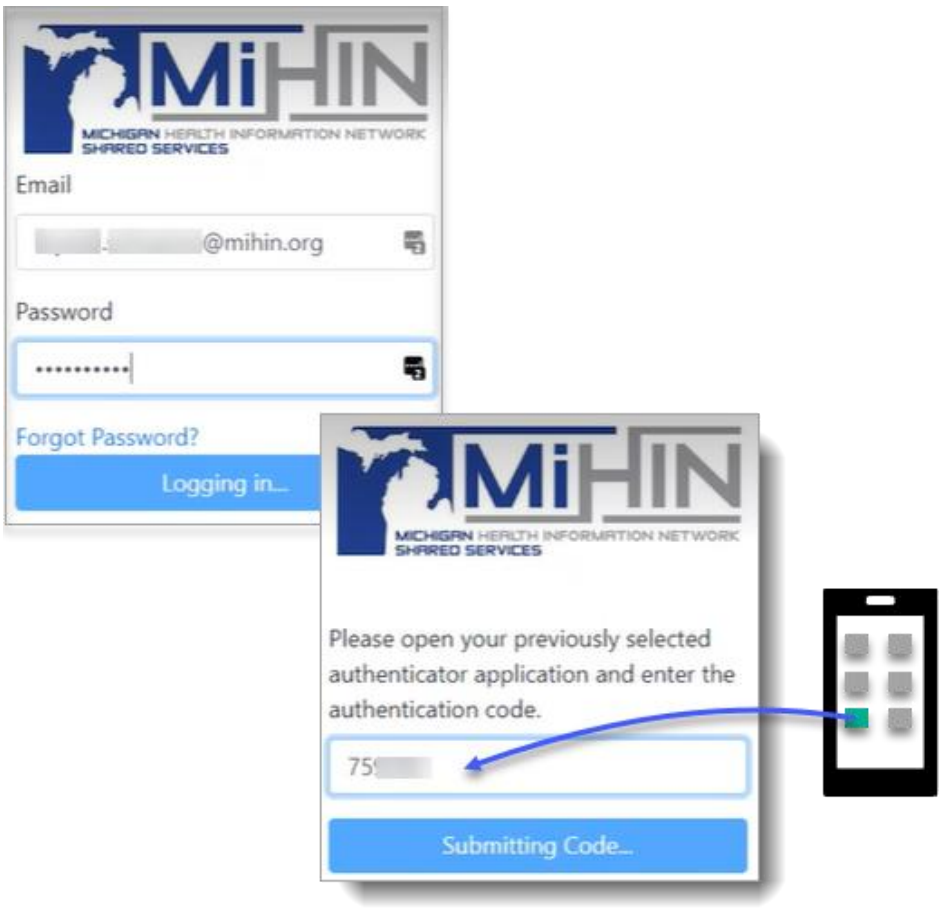
When you click in the reporting window a menu may display on the far right that allows exporting of the data.



Note*: Necessary information.*
Tip*: Helpful information.*
Caution*! Must follow information.*

Viewing Conformance Dashboards in MIGateway

1. Log in to the **MIGateway Application.**



2. Choose the **Administrative** drop down menu, and then choose **Conformance Reporting**.

3. The **Welcome to Conformance Reporting** window displays.

***Note**: If you receive a permissions warning, please contact the MiHIN Help Desk (help@mihin.org) to edit your assigned groups.*

4. Click the **vertical bar** menu in the upper left corner to open your navigation menu and display the report options for example Medrec Reports and ADT Reports.

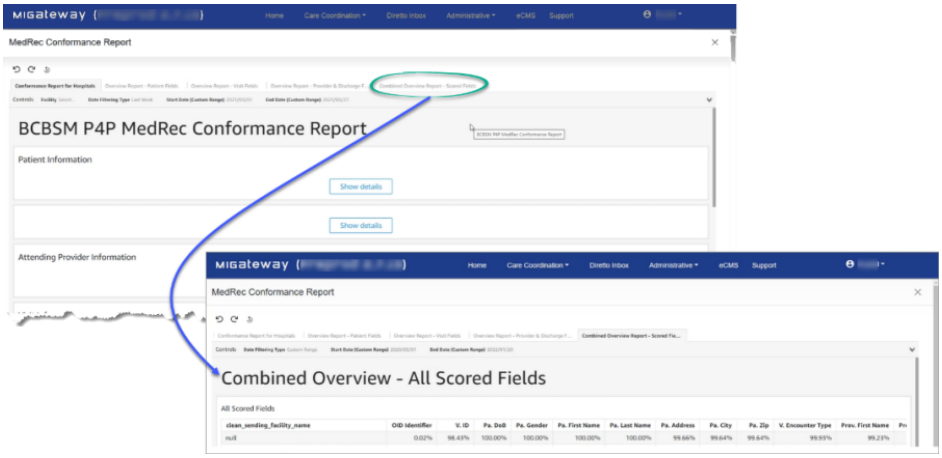
***Note:** When you choose a report option and then a report from the dashboard your report options window will display. To exit any report window, click **Close** (**X**) located in the upper right corner of the window as shown below.*

5. When you choose **MedRec Reports** your dashboard will display. Notice that as you hover over each report option a description of the report will display.

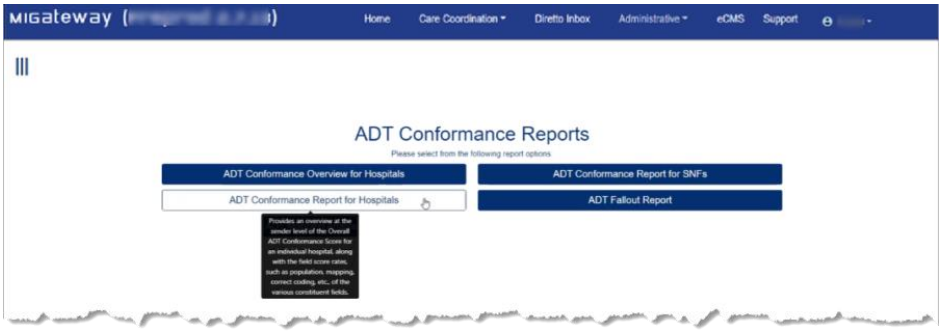
The currently available reports are:

- The MedRec Conformance Report describe overall conformance for C-CDA messages sent.
- The MedRec Fallout Report shows C-CDA messages that did not meet the conformance standards.

The **MedRec Conformance Report** shown below now has a new **Combined Overview Report – Scored Fields** tab. This report combines the data from the other three Overview Report tabs and displays the same data without the colors.



6. When you choose **ADT Reports** your dashboard will display. Notice that as you hover over each report option a description of the report will display.



The currently available reports are:

- The ADT Conformance Overview for Hospitals provides an overview at the sender level of the Overall ADT Conformance Score for organizations/groups that manage multiple Facilities along with the field score rates, such as population, mapping, correct coding, etc., of the various constituent fields.
- The ADT Conformance Report for Hospitals provides an overview at the sender level of the Overall ADT Conformance Score for an individual hospital, along with the field score rates, such as population, mapping, correct coding, etc., of the various fields.
- The ADT Conformance Report for SNFs provides an overview at the sender level of the Overall ADT Conformance Score for Skilled Nursing Facilities 9SNFs) and any organization/facility managing a Skilled Nursing Facility group, along with the field score rates, such as population, mapping, correct coding, etc., of the various constituent fields.
- The ADT Fallout Report uses the filters to find messages within the last 30 days that meet up to four separate ADT conformance criteria.
- The ADT Mapping Analysis Report uses the filters to find messages within the last 30 days that meet up to four separate ADT conformance criteria.

ADT Conformance

ADT Conformance Overview for Hospitals

This dashboard is primarily used for Organizations/Groups that manage multiple Facilities.

- **Overall Conformance Report**. Describes overall conformance rates and CKS population rates across groups/facilities.
- **Population Report: Routing Fields**.
    - (1) Each Routing ADT Conformance field and sending facility reports the frequency at which that field was populated in sent ADT messages for the period.
    - (2) Common key is included in the *PID-3.1 (CK)* in the first column and is included in the overall conformance score.
- **Population Report: Mapping Fields**. Each Mapped ADT Conformance field and sending facility reports the frequency at which that field was populated in messages that are sent.
- **Population Report: Correct Coding Fields**. Each Mapped/Correct Coding ADT Conformance field and sending facility reports the frequency at which that field was populated in ADT messages that are sent.
- **Mapping Report**. Each Mapped ADT Conformance field and sending facility reports the percentage of values in those fields which were properly mapped based on supplied values in the message and mapping table.
- **Correct Coding Report**. Each Correct Coding ADT Conformance field and sending facility reports the percentage of values in those fields which contained values reflecting properly coded contents for this period.

ADT Conformance Report for Skilled Nursing Facilities

This dashboard is used for Skilled Nursing Facilities (SNFs) and any organization/facility managing a SNF group.

- **Overall Conformance Report**. Describes overall conformance rates and Common Key Service (CKS) population rates across groups/facilities
- **Population Report: Routing Fields**. Each Routing ADT Conformance field and sending facility, reports the frequency at which that field was populated in ADT messages that are sent for the period. Common key is included in the *PID-3.1 (CK)* in the first column and is included in the overall conformance score.
- **Population Report: Mapping Fields**. Each Mapped ADT Conformance field and sending facility, reports the frequency at which that field was populated in ADT messages that are sent.
- **Population Report: Correct Coding Fields**. Each Mapped/Correct Coding ADT Conformance field and sending facility, reports the frequency at which that field was populated in ADT messages that are sent.

- **Mapping Report**. Each Mapped ADT Conformance field and sending facility, reports the percentage of values in those fields which were properly mapped based on supplied values in the message and mapping table.
- **Correct Coding Report**. Each Correct Coding ADT Conformance field and sending facility, reports the percentage of values in those fields which contained values reflecting properly coded contents for this period.

ADT Conformance Report for Hospitals

This dashboard is primarily used for individual hospitals.

- **Hospital ADT Conformance Report**. Provides an overview at the sender level of the Overall ADT Conformance Score for that organization, along with the field score rates, such as population, mapping, correct coding, etc., of the various constituent fields.
- **Hospital ADT Conformance Population Report for Hospitals**. Provides a detailed overview of which fields were populated at what rate across various ADT Trigger Types, for example, A01, A03, A08, etc.

ADT Mapping Analysis Report

Use the filters to find messages within the last 30 days to meet up to four separate ADT conformance criteria.

Note: *This report is up to date from the last mapping table load.*

ADT Mapping Analysis Report Field Controls with Definitions

Use the following controls to generate the ADT Mapping Analysis Report.

1. Use the **Facility** arrow to choose the facility name which will display in the report below.

2. Click the **Field of Interest** arrow and using the check box, select one or more items from the options list.

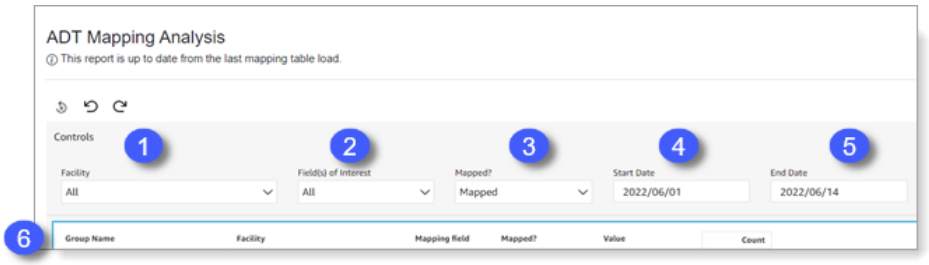
3. Using the **Mapped?** arrow to choose from the following list:

    - Mapped
    - Not Mapped

4. Type the **Start Date** in YYYY/MM/DD format or use the calendar tool to choose.

5. Accept the default or use the calendar tool to choose an **End Date**.

***Note**: The* same *start and end date cannot be used for the search period, as a time of midnight is assumed. In order to view one day of data, you must select the date of interest as the start date and then the next day as the end date.*



6. When your report displays you will see the following information:

-
  - **Group Name**. Displays as a provider health system name.
  - **Facility**. Displays as the hospital name that you chose using the Facility arrow.
  - **Mapping field**. Displays a list of fields that are noted in the ADT messages.
  - **Mapped?** Displays whether the field is mapped or not mapped. Each mapped field will have specific values mapped to the mapping table for that Facility.
  - **Value**. The value will vary between a character, number, or word as defined by the Facility and HL7 Standards.
  - **Count**. The total amount of values that were mapped to the mapping table for a particular field.

ADT Fallout Report

Use the filters to find messages within the last 30 days that meet up to four separate ADT conformance criteria.

ADT Conformance Report Field Definitions and Controls

Use the following controls to generate the ADT Fallout Report.

Number of Messages. Click the drop-down arrow to choose the number of messages to show.

1. **Facility/Group**. Click the drop-down arrow to choose the facility or group name.
2. **Trigger Type(s)**. Accept the default or choose a trigger type.
3. **Search Period Start Date**. Accept the default or click to use the calendar and choose a start date.
4. **Search Period End Date**. Accept the default or click to use the calendar and choose an end date.

***Note**: The same start and end date cannot be used for the search period, as a time of midnight is assumed. In order to view one day of data, you must select the date of interest as the start date and then the next day as the end date.*

6. **Field of Interest**. Click the dropdown arrow and choose a field name.

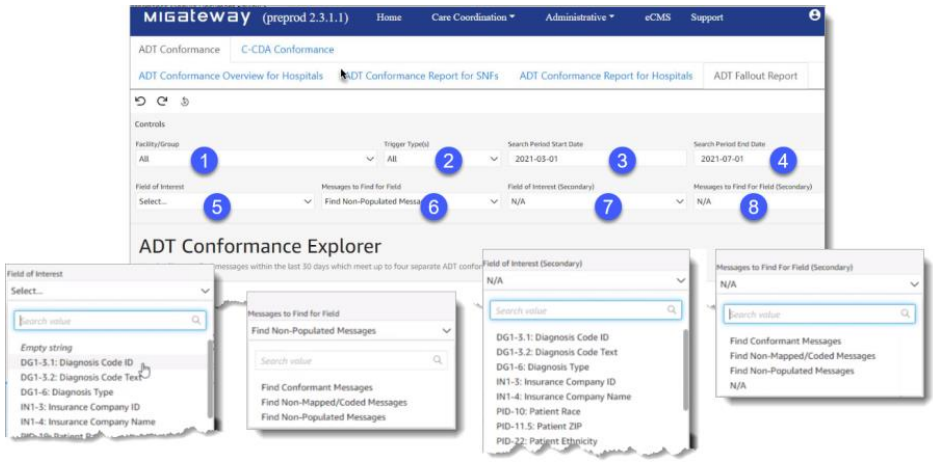
7. **Messages to Find for Field**. Then use your **Find Non-Populated Messages** dialog to choose from the following list:

- Find Conformant Messages
- Find Non-Mapped/Coded Messages
- Find Non-Populated Messages

7. **Field of Interest (Secondary)**. Click the dropdown arrow to choose from the following list:

- Find Conformant Messages
- Find Non-Mapped/Coded Messages
- Find Non-Populated Messages
- N/A

8. **Messages to Find for Field (Secondary)**. Click the dropdown arrow and choose a field name.



Downloading ADT Mapping Analysis Report

1. Open the **report** you would like to download.
2. When you hover on the right-hand side of the report, a **toolbar** will display.
3. Click the **toolbar**.
4. Choose the **ellipsis** (**…**).
5. Choose either **Export to CSV** or **Export to Excel**.

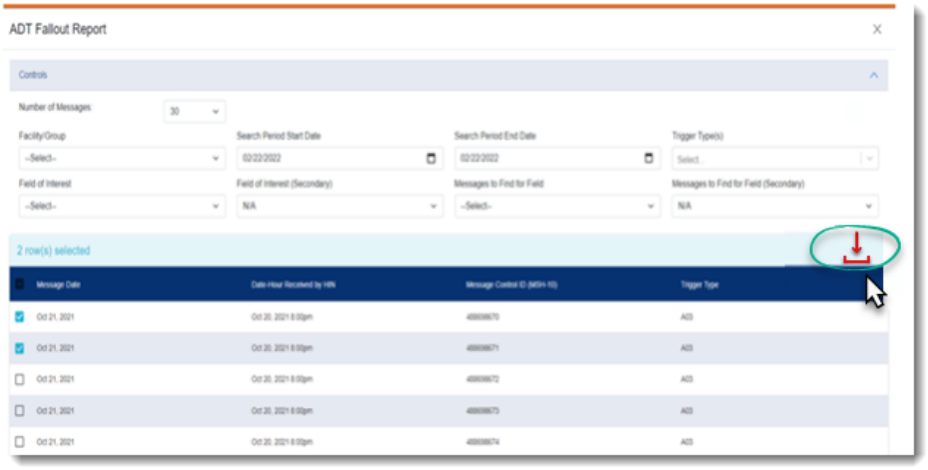
Downloading ADT Conformance Fallout Report messages

1. When the ADT Conformance Fallout Report displays, review the list of messages on the left.

    a. Then select one or more **messages** by clicking individual message check boxes,

    b. or use the **Select All** messages tool to select all messages at once.

2. Click the **Download** icon to download selected messages.



3. The message(s) will download and display at the bottom of your browser, double-click to open the message(s).

Note: *The messages will display in a box at the bottom of the page as a zip folder.*

ADT Event Type Definitions

Below is a table of HL7 ADT message types and associated descriptions that you can reference when reviewing the ADT reports.

Message Type	Message Description
A01	Admit/Visit Notification
A02	Transfer a Patient
A03	Discharge/End Visit
A04	Register a Patient
A05	Pre-Admit a Patient
A06	Change an Outpatient to an Inpatient
A07	Change an Inpatient to an Outpatient
A08	Update Patient Information
A09	Patient Departing - Tracking
A10	Patient Arriving - Tracking
A11	Cancel Admit/Visit Notification
A12	Cancel Transfer
A13	Cancel Discharge/End Visit
A14	Pending Admit
A15	Pending Transfer
A16	Pending Discharge
A17	Swap Patients
A18	Merge Patient Information
A21	Patient Goes on a Leave of Absence
A22	Patient Returns from a Leave of Absence
A23	Delete a Patient Record
A25	Cancel Pending Discharge

A26	Cancel Pending Transfer
A27	Cancel Pending Admit
A28	Add Person or Patient Information
A29	Delete Person Information
A34	Merge Patient Information - Patient ID Only
A35	Merge Patient Information - Account Number Only
A36	Merge Patient Information - Patient ID & Account Number
A38	Cancel Pre-Admit
A40	Merge Patient - Patient Identifier List
A41	Merge Account - Patient Account Number
A44	Move Account Information - Patient Account Number
A45	Move Visit Information - Visit Number
A52	Cancel Patient Returns from a Leave of Absence

Conformance Scoring Criteria

The Population Requirements for Messages chart below displays the required ADT data and conformance thresholds. Using this chart, you can find the targets needed for conformance scores. The message types display on the left with the corresponding segments to the right. The bolded lines divide the segments into three sections: routing data, complete mapping, and coding standards.
Notes regarding CKS Field Measurement:

- In order for the conformance score to count for PID-3.1, PID-3.5 must be populated with the value "CKS".
- Any iteration of PID-3.1 must be populated with the patient's Common Key Service attribute.

Population Requirements for Messages

Patient Class (PV1-2) Exclusions/Inclusions
Outpatient, Pre-Admit, Recurring, Commerical Account Always Excluded
Inpatient Only (PV1-4, PV1-14, PV1-17)
Inpatient or Emergency Only (DG1-3.1, DG1-3.2, DG1-6, and PV1-7)

	Complete Routing Data														Complete Mapping										Coding Standards			
Message Type	PID-3.1	PID-5.1	PID-5.2	PID-7	PID-11.5	PV1-19	PID-29*	PID-30	PID-19	PV1-37	PV1-44	PV1-45	IN1-3	IN1-4	MSH-4.1	PID-8	PID-10	PID-22	PV1-2	PV1-4	PV1-10	PV1-14	PV1-36	DG1-6	DG1-3.1	DG1-3.2	PV1-7	PV1-17
A01	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%		≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%						
A02	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A03	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%
A04	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A05	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%		≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A06	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%		≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A07	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%		≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A08	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%			N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A09	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A10	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A11	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A12	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A13	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%		≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A14	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%		≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A15	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A16	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%		≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A17	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A18	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A21	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A22	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A23	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A25	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A26	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A27	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A						≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A28	≥60%	≥95%	≥95%	≥95%	≥95%		≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%		≥95%		≥95%						
A29	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A						≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A34	≥60%	≥95%	≥95%	≥95%	≥95%		≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A35	≥60%	≥95%	≥95%	≥95%	≥95%		≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A36	≥60%	≥95%	≥95%	≥95%	≥95%		≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A38	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A40	≥60%	≥95%	≥95%	≥95%	≥95%		≥95%	≥95%	N/A						≥95%	≥95%	≥95%	≥95%										
A41	≥60%	≥95%	≥95%	≥95%	≥95%		≥95%	≥95%	N/A						≥95%	≥95%	≥95%	≥95%										
A44	≥60%	≥95%	≥95%	≥95%	≥95%		≥95%	≥95%	N/A						≥95%	≥95%	≥95%	≥95%										
A45	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
A52	≥60%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	≥95%	N/A		≥95%				≥95%	≥95%	≥95%	≥95%	≥95%	≥95%		≥95%						
							*PID-29 only measured where PID-30 indicates "Y/Yes" that the patient is deceased.																					

C-CDA Conformance

This section describes the reports available for C-CDA Conformance including field definitions and controls related to C-CDA.

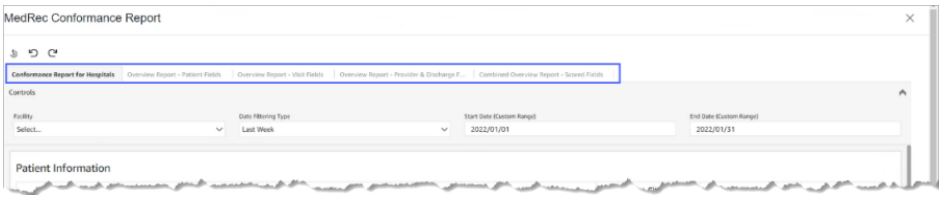
MedRec Conformance Report

Describes overall conformance rates for C-CDA messages sent.

Field Definitions and Controls

Choose a tab to generate the following reports.

- **Conformance Report for Hospitals**. Base report for all sections.
- **Overview Report**. Patient Fields.
- **Overview Report**. Visit Fields.
- **Overview Report**. Provider and Discharge Fields.
- **Combined Overview Report**. Scored Fields.



MedRec Fallout Report

Shows C-CDA messages that did not meet the conformance thresholds.

Field Definitions and Controls

Use the following controls to filter the C-CDA report for the specific criteria information you need:

1. **Number of Messages**. Use the arrow to choose the number of messages to display.
2. **Facility/Group**
3. **Date Filtering Type**
    - Custom Range
    - Last Week
    - Last Month
    - Last Quarter
    - Last Year
    - Yesterday
4. **Start Date (Custom Range)**. This field will only affect the data selection if the **Period of Interest** field is set to the value of **Custom Range**.
5. **End Date (Custom Range)**. This field will only affect the data selection if the **Period of Interest** field is set to the value of **Custom Range**.
6. **Conformance Field of Interest**. Use this field to choose specific criteria such as patient name.
7. **Conformance Status**. Accept the default or choose a status from the dropdown list.

Required XPaths

Below is a list of the XPaths used in the XML document. The **Description** column contains the data elements within the C-CDA Conformance report. The **Xpaths** column contains what is used to determine the presence of the data element.

Section	Description	Xpaths
Header Section	**Provider Organization**	recordTarget/patientRole/providerOrganization/name or author/assignedAuthor/representedOrganization/name
	Facility OID	recordTarget/patientRole/providerOrganization/id/extension == [MSH-4.1^MSH-4.2 (should match OIDs sent in ADTs]
	EMR	author/assignedAuthor/assignedAuthoringDevice/manufacturerModelName
	Patient First Name	recordTarget/patientRole/patient/name/given
	Patient Last Name	recordTarget/patientRole/patient/name/family
	Patient Date of Birth	recordTarget/patientRole/patient/birthTime
	Patient Gender	recordTarget/patientRole/patient/administrativeGenderCode/code
	Patient SSN	if recordTarget/patientRole/id/root == "2.16.840.1.113883.4.1" then recordTarget/patientRole/id/extension

	Patient Address	recordTarget/patientRole/addr/streetAddressLine
	Patient City	recordTarget/patientRole/addr/city
	Patient State	recordTarget/patientRole/addr/state
	Patient Zip Code	recordTarget/patientRole/addr/postalCode
	Visit ID	componentOf/encompassingEncounter/id/extension
	Progress Note	templateId/root == "2.16.840.1.113883.10.20.22.1.9"
	Attending Provider First Name	documentationOf/serviceEvent/performer/assignedEntity/assignedPerson/name/given or componentOf/encompassingEncounter/encounterParticipant/assignedEntity/assignedPerson/name/given
	Attending Provider Last Name	documentationOf/serviceEvent/performer/assignedEntity/assignedPerson/name/family or componentOf/encompassingEncounter/encounterParticipant/assignedEntity/assignedPerson/name/family
	Attending Provider NPI	documentationOf/serviceEvent/performer/assignedEntity/id/extension or componentOf/encompassingEncounter/encounterParticipant/assignedEntity/id/extension

	Attending Provider Phone	documentationOf/serviceEvent/performer/assignedEntity/telecom/value or componentOf/encompassingEncounter/encounterParticipant/assignedEntity/telecom/value
Component Section	**Admission Medications**	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.1 " or "2.16.840.1.113883.10.20.22.2.1.1" or "2.16.840.1.113883.10.20.22.2.38"
	Active Problems	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.5" or "2.16.840.1.113883.10.20.22.2.5.1"
	Admission Medications	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.1 " or "2.16.840.1.113883.10.20.22.2.1.1" or "2.16.840.1.113883.10.20.22.2.38"
	Advanced Directives	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.4.48" or "2.16.840.1.113883.10.20.22.2.21" or "2.16.840.1.113883.10.20.22.2.21.1"
	Allergies	if component/structuredBody/component/section/templateId/root =="2.16.840.1.113883.10.20.22.2.6.1"
	Chief Complaint	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.12" or "2.16.840.1.113883.10.20.22.2.13" or "1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1"
	Discharge Instructions	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.41"
	Encounter Type	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.22.1" or "2.16.840.1.113883.10.20.22.2.22" or "2.16.840.1.113883.10.20.22.4.49"
	Functional Status	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.14"
	Immunizations	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.2" or "2.16.840.1.113883.10.20.22.2.2.1"

	Plan of Care	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.10"
	Procedures	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.7" or "2.16.840.1.113883.10.20.22.2.7.1"
	Reason for Referral	if component/structuredBody/component/section/templateId/root == 1.3.6.1.4.1.19376.1.5.3.1.3.1
	Results/Laboratory Values	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.3.1"
	Social History	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.17"
	Tests Ordered	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.16"
	Visit Diagnosis	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.24 " or "2.16.840.1.113883.10.20.22.2.43" or "2.16.840.1.113883.10.20.22.2.8"
	Visit Diagnosis Description	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.22" or "2.16.840.1.113883.10.20.22.2.22.1" then component/structuredBody/component/section/templateId/entry/encounter/templateId/root ="2.16.840.1.113883.10.20.22.4.49"/entryRelationship/act/templateId/root == "2.16.840.1.113883.10.20.22.4.80"
	Vital Signs	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.4.1" or "2.16.840.1.113883.10.20.22.2.4"

	Discharge Medication Name	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/consumable/manufacturedProduct/manufacturedMaterial/code/displayName or if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/consumable/manufacturedProduct/manufacturedMaterial/code/translation/displayName or if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/consumable/*manufacturedProduct*/manufacturedMaterial/code/originalText

	Discharge Medication Code	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/consumable/manufacturedProduct/manufacturedMaterial/code/codeSystemName== "RxNorm" or "NDC" or if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/consumable/manufacturedProduct/manufacturedMaterial/code/translation/codeSystemName== "RxNorm" or "NDC"
	Discharge Medication Begin Date	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/effectiveTime/low/value
	Discharge Medication End Date	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/effectiveTime/high/value

	Discharge Medication Status	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/statusCode/code
	Discharge Medication Dose Unit	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/doseQuantity/unit
	Discharge Medication Dose Quantity	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/doseQuantity/value

	Discharge Medication Instructions	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/entryRelationship/act/templateId/root == "2.16.840.1.113883.10.20.22.4.20" or if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templateId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.16"/entryRelationship/substanceAdministration/templateId/root == "2.16.840.1.113883.10.20.22.4.147"

Template OID Descriptions

This table is a list of the template Object Identifiers (OIDs) used in each section.

Template OID	Title	Description
2.16.840.1.113883.10.20.22.2.1	Medications	The Medications section defines a patient's current medications and pertinent medication history. At a minimum, the currently active medications are to be listed, with an entire medication history as an option. The section may also include a patient's prescription and dispense history.

2.16.840.1.113883.10.20.22.2.1.1	Medications	The Medications section defines a patient's current medications and pertinent medication history. At a minimum, the currently active medications are to be listed, with an entire medication history as an option. The section may also include a patient's prescription and dispense history. This section requires that there be either an entry indicating the subject is not known to be on any medications, or that there be entries summarizing the subject's medications.
2.16.840.1.113883.10.20.22.2.38	Medications Administered	The Medications Administered section defines medications and fluids administered during the procedure, encounter, or other activity excluding anesthetic medications. This guide recommends anesthesia medications be documented as described in the section on Anesthesia.
2.16.840.1.113883.10.20.22.2.11	Hospital Discharge Medications List	The Hospital Discharge Medications section defines the medications that the patient is intended to take (or stop) after discharge. The currently active medications must be listed. The section may also include a patient's prescription history and indicate the source of the medication list, for example, from a pharmacy system versus from the patient.
2.16.840.1.113883.10.20.22.2.11.1	Hospital Discharge Medications	The Hospital Discharge Medications section defines the medications that the patient is intended to take (or stop) after discharge. At a minimum, the currently active medications should be listed with an entire medication history as an option. The section may also include a patient's prescription history and indicate the source of the medication list, for example, from a pharmacy system versus from the patient.

2.16.840.1.113883.10.20.22.4.35	Discharge Medication Code	The Discharge Medications entry codes medications that the patient is intended to take (or stop) after discharge.
2.16.840.1.113883.10.20.22.4.16	Medication Activity	A medication activity describes substance administrations that have actually occurred, for example, pills ingested or injections given) or are intended to occur, for example, "take 2 tablets twice a day for the next 10 days"). Medication activities in "INT" mood are reflections of what a clinician intends a patient to be taking. Medication activities in "EVN" mood reflect actual use. Medication timing is complex. This template requires that there be a substanceAdministration/effectiveTime valued with a time interval, representing the start and stop dates. Additional effectiveTime elements are optional and can be used to represent frequency and other aspects of more detailed dosing regimens.
2.16.840.1.113883.10.20.22.2.24	Hospital Discharge Diagnosis	The Hospital Discharge Diagnosis section describes the relevant problems or diagnoses at the time of discharge that occurred during the hospitalization or that need to be followed after hospitalization. This section includes an optional entry to record patient conditions.
2.16.840.1.113883.10.20.22.2.43	Admitting Diagnoses	The Hospital Admitting Diagnosis section contains a narrative description of the primary reason for admission to a hospital facility. The section includes an optional entry to record patient conditions.

2.16.840.1.113883.10.20.22.2.8	Assessments	The Assessment section (also called impression or diagnoses) represents the clinician's conclusions and working assumptions that will guide treatment of the patient. The assessment formulates a specific plan or set of recommendations. The assessment may be a list of specific disease entities or a narrative block.
2.16.840.1.113883.10.20.22.2.5	Problem List	This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed.
2.16.840.1.113883.10.20.22.2.5.1	Problems	This section lists and describes all relevant clinical problems at the time the document is generated. At a minimum, all pertinent current and historical problems should be listed.
2.16.840.1.113883.10.20.22.2.12	Reason for Visit	This section records the patient's reason for the patient's visit (as documented by the provider). Local policy determines whether Reason for Visit and Chief Complaint are in separate or combined sections.
2.16.840.1.113883.10.20.22.2.13	Chief Complaint and Reason for Visit	This section records the patient's chief complaint (the patient's own description) and/or the reason for the patient's visit (the provider's description of the reason for visit). Local policy determines whether the information is divided into two sections or recorded in one section serving both purposes.
1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1	Chief Complaint	This section records the patient's chief complaint (the patient's own description).

2.16.840.1.113883.10.20.22.2.6.1	Allergies	This section lists and describes any medication allergies, adverse reactions, idiosyncratic reactions, anaphylaxis/anaphylactoid reactions to food items, and metabolic variations or adverse reactions/allergies to other substances (such as latex, iodine, tape adhesives) used to assure the safety of health care delivery. At a minimum, it should list currently active and any relevant historical allergies and adverse reactions.
2.16.840.1.113883.10.20.22.4.48	Advanced Directive Observation	Advanced Directives Observations assert findings, for example, "resuscitation status is Full Code" rather than orders and should not be considered legal documents. A legal document can be referenced using the reference/externalReference construct.
2.16.840.1.113883.10.20.22.2.21	Advanced Directives	This section contains data defining the patient's advance directives and any reference to supporting documentation. The most recent and up-to-date directives are required, if known, and should be listed in as much detail as possible. This section contains data such as the existence of living wills, healthcare proxies, and CPR and resuscitation status. If referenced documents are available, they can be included in the CCD exchange package. *Note*: The descriptions in this section differentiate between "advance directives" and "advance directive documents." The former are the directions whereas the latter are legal documents containing those directions. Thus, an advance directive might be "no cardiopulmonary resuscitation," and this directive might be stated in a legal advance directive document.

2.16.840.1.113883.10.20.22.2.21.1	Advanced Directives	This section contains data defining the patient's advance directives and any reference to supporting documentation. The most recent and up-to-date directives are required, if known, and should be listed in as much detail as possible. This section contains data such as the existence of living wills, healthcare proxies, and CPR and resuscitation status. If referenced documents are available, they can be included in the CCD exchange package. *Note*: The descriptions in this section differentiate between "advance directives" and "advance directive documents." The former are the directions whereas the latter are legal documents containing those directions. Thus, an advance directive might be "no cardiopulmonary resuscitation," and this directive might be stated in a legal advance directive document.
2.16.840.1.113883.10.20.22.2.4	Vital Signs	The Vital Signs section contains relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, and pulse oximetry. The section should include notable vital signs such as the most recent, maximum and/or minimum, baseline, or relevant trends. Vital signs are represented in the same way as other results but are aggregated into their own section to follow clinical conventions.

2.16.840.1.113883.10.20.22.2.4.1	Vital Signs	The Vital Signs section contains current and historically relevant vital signs for the context and use case of the document type, such as blood pressure, heart rate, respiratory rate, height, weight, body mass index, head circumference, and pulse oximetry. The section should include notable vital signs such as the most recent, maximum and/or minimum, baseline, or relevant trends. Vital signs are represented in the same way as other results but are aggregated into their own section to follow clinical conventions.
2.16.840.1.113883.10.20.22.2.41	Hospital Discharge Instructions	The Hospital Discharge Instructions section records instructions at discharge.

2.16.840.1.113883.10.20.22.2.14	Functional Status	The Functional Status section describes the patient's physical state, status of functioning, and environmental status at the time the document was created. A patient's physical state may include information regarding the patient's physical findings as they relate to problems, including but not limited to: • Pressure Ulcers • Amputations • Heart murmur • Ostomies A patient's functional status may include information regarding the patient relative to their general functional and cognitive ability, including: • Ambulatory ability • Mental status or competency • Activities of Daily Living (ADLs), including bathing, dressing, feeding, grooming • Home or living situation having an effect on the health status of the patient • Ability to care for self • Social activity, including issues with social cognition, participation with friends and acquaintances other than family members • Occupation activity, including activities partly or directly related to working, housework or volunteering, family and home responsibilities or activities related to home and family • Communication ability, including issues with speech, writing or cognition required for communication • Perception, including sight, hearing, taste, skin sensation, kinesthetic sense, proprioception, or balance A patient's environmental status may include information regarding the patient's current exposures from their daily environment, including but not limited to: • Airborne hazards such as second-hand smoke, volatile organic compounds, dust, or other allergens • Radiation • Safety hazards in home, such as throw rugs, poor lighting, lack of railings/grab bars, etc. • Safety hazards at work, such as communicable diseases, excessive heat, excessive noise, etc. The patient's functional status may be expressed as a problem or as a result observation. A functional or cognitive

		status problem observation describes a patient's problem, symptoms, or condition. A functional or cognitive status result observation may include observations resulting from an assessment scale, evaluation or question and answer assessment. Any deviation from normal function displayed by the patient and recorded in the record should be included. Of particular interest are those limitations that would interfere with self-care or the medical therapeutic process in any way. In addition, a note of normal function, an improvement, or a change in functioning status may be included.
2.16.840.1.113883.10.20.22.2.2	Immunizations	The Immunizations section defines a patient's current immunization status and pertinent immunization history. The primary use case for the Immunization section is to enable communication of a patient's immunization status. The section should include current immunization status and may contain the entire immunization history that is relevant to the period of time being summarized.
2.16.840.1.113883.10.20.22.2.2.1	Immunizations	The Immunizations section defines a patient's current immunization status and pertinent immunization history. The primary use case for the Immunization section is to enable communication of a patient's immunization status. The section should include current immunization status and may contain the entire immunization history that is relevant to the period of time being summarized.

2.16.840.1.113883.10.20.22.2.10	Plan of Care	The Plan of Care section contains data that defines pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only, which are indicated by the @moodCode of the entries within this section. All active, incomplete, or pending orders, appointments, referrals, procedures, services, or any other pending event of clinical significance to the current care of the patient should be listed unless constrained due to privacy issues. The plan may also contain information about ongoing care of the patient and information regarding goals and clinical reminders. Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and health-care quality improvements, including widely accepted performance measures. The plan may also indicate that patient education will be provided.

2.16.840.1.113883.10.20.22.2.7	Procedures	This section defines all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section is intended to include notable procedures but can contain all procedures for the period of time being summarized. The common notion of "procedure" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore, this section contains procedure templates represented with three RIM classes: Act. Observation, and Procedure. Procedure act is for procedures the alter that physical condition of a patient (Splenectomy). Observation act is for procedures that result in new information about a patient but do not cause physical alteration (EEG). Act is for all other types of procedures (dressing change). The length of an encounter is documented in the documentationOf/encompassingEncounter/effectiveTime and length of service in documentationOf/ServiceEvent/effectiveTime.

2.16.840.1.113883.10.20.22.2.7.1	Procedures	This section defines all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically at the time the document is generated. The section may contain all procedures for the period of time being summarized but should include notable procedures. The common notion of ""procedure"" is broader than that specified by the HL7 Version 3 Reference Information Model (RIM). Therefore, this section contains procedure templates represented with three RIM classes: Act. Observation, and Procedure. Procedure act is for procedures the alter that physical condition of a patient (Splenectomy). Observation act is for procedures that result in new information about a patient but do not cause physical alteration (EEG). Act is for all other types of procedures (dressing change).
1.3.6.1.4.1.19376.1.5.3.1.3.1	Reason for Referral	A Reason for Referral section records the reason the patient is being referred for a consultation by a provider. An optional Chief Complaint section may capture the patient's description of the reason for the consultation.

2.16.840.1.113883.10.20.22.2.3.1	Results	The Results section contains the results of observations generated by laboratories, imaging procedures, and other procedures. The scope includes observations such as hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. The section often includes notable results such as abnormal values or relevant trends and could contain all results for the period of time being documented. Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory. Imaging results are typically generated by a clinician reviewing the output of an imaging procedure, such as where a cardiologist reports the left ventricular ejection fraction based on the review of a cardiac echocardiogram. Procedure results are typically generated by a clinician to provide more granular information about component observations made during a procedure, such as where a gastroenterologist reports the size of a polyp observed during a colonoscopy.

2.16.840.1.113883.10.20.22.2.17	Social History	This section contains data defining the patient's occupational, personal, for example, lifestyle), social, and environmental history and health risk factors, as well as administrative data such as marital status, race, ethnicity, and religious affiliation. Social history can have significant influence on a patient's physical, psychological, and emotional health and wellbeing so should be considered in the development of a complete record.
2.16.840.1.113883.10.20.22.2.22.1	Encounters	This section lists and describes any 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. It is also a contact between a patient and a practitioner who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment. This section may contain all encounters for the time period being summarized but should include notable encounters.

2.16.840.1.113883.10.20.22.2.22	Encounters	This section lists and describes any 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. It is also a contact between a patient and a practitioner who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment. This section may contain all encounters for the time period being summarized but should include notable encounters.
2.16.840.1.113883.10.20.22.4.49	Encounter Activities	This clinical statement describes the interactions between the patient and clinicians. Interactions include in-person encounters, telephone conversations, and email exchanges.

2.16.840.1.113883.10.20.22.2.16	Hospital Discharge Studies Summary	This section records the results of observations generated by laboratories, imaging procedures, and other procedures. The scope includes hematology, chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure observations. This section often includes notable results such as abnormal values or relevant trends and could record all results for the period of time being documented. Laboratory results are typically generated by laboratories providing analytic services in areas such as chemistry, hematology, serology, histology, cytology, anatomic pathology, microbiology, and/or virology. These observations are based on analysis of specimens obtained from the patient and submitted to the laboratory. Imaging results are typically generated by a clinician reviewing the output of an imaging procedure, such as where a cardiologist reports the left ventricular ejection fraction based on the review of an echocardiogram. Procedure results are typically generated by a clinician wanting to provide more granular information about component observations made during the performance of a procedure, such as when a gastroenterologist reports the size of a polyp observed during a colonoscopy. Note that there are discrepancies between CCD and the lab domain model, such as the effectiveTime in specimen collection.

XPath Exclusions Table

When the XPaths listed in the table below are present, the Discharge Medication Fields are excluded from the measurement scoring criteria.

Description	Path
When the following XPaths are present the message shall be ***excluded*** from measurement for **Discharge Medication** fields **(Code, Name, Instructions, Dose Quantity, Dose Unit, Begin Date, End Date,** and **Status)**.	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/text/paragraph/"No Known Medications"
	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/content/"No Current Hospital Discharge Medications"
	if component/structuredBody/component/section/templateId/root == "2.16.840.1.113883.10.20.22.2.11" or "2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/content/"Hospital Discharge Medications excluded/not available"

When the following XPath is present, the document is tagged as an *ambulatory CCD* and excluded from *Discharge Med Rec* conformance: componentOf/encompassingEncounter/code/@code == "AMB"

***Note**: Conformance may be measured separately on these message types at a future date.*

Downloading C-CDA Fallout Report messages

1. Log in to **MIGateway**.
2. Choose the **Administrative** dropdown menu, and then choose **Conformance Reporting**.
3. On the **Conformance Reporting** window, choose **C-CDA Conformance**.
4. Choose the **C-CDA Fallout Report** tab to access your fallout messages.

a. Using the **Number of Messages** arrow, choose the number of messages to display.

b. Use your **Facility/Group** arrow to scroll and select a facility or group.

c. Choose the time period using the **Date Filtering Type** arrow.

d. If you would like to search a specific time frame not included in the *Date Filtering Type* option menu, use the **Calendar** tool in the **Start Date (Custom Range)** and **End Date (Custom Range)** boxes to set the custom start and end date or type the dates in MM/DD/YYYY format.

e. Choose your **Conformance Field of Interest from the options list**.

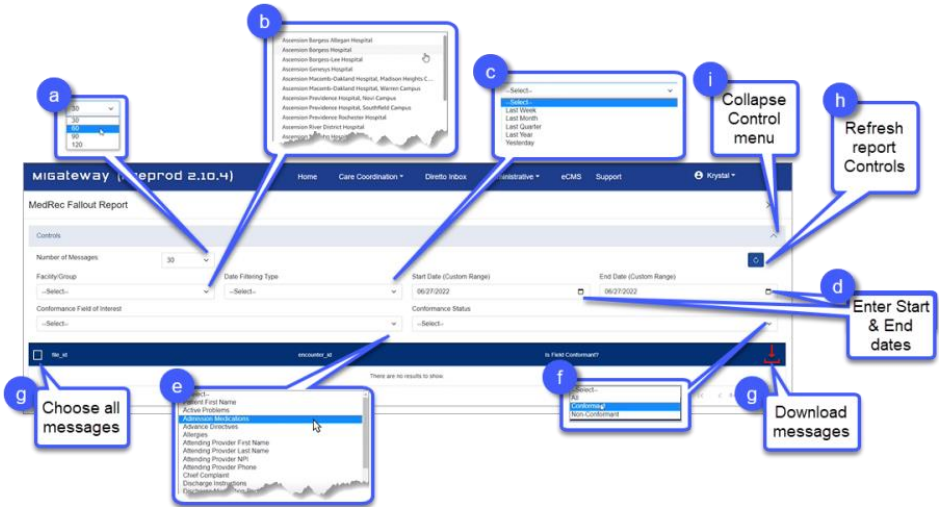
f. Choose your **Conformance Status**.

g. Each message will display below the *Controls* in your browser with a **Choose message** toggle to the left. Click the toggle to select individual messages and then click **Download** ( ) to display. When all messages are required, click the **Choose all messages** toggle to select all messages.

h. When requesting another report, make your choices and then use the **Refresh** tool to update the new choices.

> ***Caution!*** *Do not use your browser* `Refresh` *tool. Doing so will return you to the logon window.*

i. The **Controls** menu can be collapsed by clicking the **Collapse** arrow.



Lab Conformance

Statewide Lab Conformance Report

The *Statewide Lab Conformance Report* describes the overall conformance rates for lab Observation Result (ORU) messages sent.

Data may be pulled back to August 1, 2022.

> ***Note**: The report displays the population of each segment. The report does* not *currently take into consideration the content of each segment.*

Lab Conformance Report Fields

Segment	Field identifiers	Description
MSH	MSH-3.1	Sending Application Namespace ID
	MSH-4.1	Sending Facility Namespace ID
	MSH-4.2	Sending Facility Universal ID Date/Time of Message
	MSH-9.2	Trigger Event
	MSH-10	Message Control ID
PID	PID-2	Patient ID
	PID-5.1	Patient Family Name
	PID-5.2	Patient Given Name
	PID-7	DOB
	PID-8	Gender

	PID-10	Race
	PID-11.1	Street Address
	PID-11.5	ZIP
PV	PV1-2	Patient Class
OBR	OBR-3.1	Entity Identifier
	OBR-4	Universal Service Identifier
	OBR-16	Ordering Provider
OBX	OBX-2	Value Type
	OBX-3	Observation Identifier
	OBX-5	Observation Value
	OBX-11	Observation Result Status

Appendix A: FAQs

Overall ADT Conformance Score

How is the ADT Conformance Score Calculated?

This field is not scored based on an average of all scores. Each field gets scored out of 1 point, there are a total of 26 or 27 fields depending on the peer group you are in. Some fields are measured in two ways, both ways must pass in order to receive a point. For example, for the fields that have both a population and a mapping, they must both be in the 'green' or 'passing' to receive the point. If population is green, but mapping is red, no point was given. PID-8 is a great example of a two-field point system to review. The overall score is then calculated based on how many of the fields have received a point. If 19 of 26 fields are compliant, the score given is 73%.

Questions and Answers for Conformance

We do not have a diagnosis until after discharge, can you use the diagnosis in the A08 message instead?
No, the diagnosis must be in A03 Discharge message. The diagnosis does not have to be the final diagnosis. The working diagnosis or even a coding of the chief complaint could be sent until a final diagnosis is determined.

On the field PID 3.1 CK, If MiHIN does not assign a Common Key does it still count against me?
Common Key assignment from MiHIN, is not the same as Common Key in Conformance. PID 3.1 is measuring if there was a common key included in the message.
Why do I have a blank field in the Conformance Module dashboard?
There were not any messages meeting the criteria for measurement of that field.
What if a patient leaves without being seen? They do not have a diagnosis to add.
The diagnosis does not have to be a final diagnosis, it could be a diagnosis for the patient's chief complaint. You could send Z53.21 as the description is, "Procedure and treatment not carried out due to patient leaving prior to being seen by health care provider." Another alternative is to send an A11 cancel admit instead of an A03 discharge notification.
I am changing the dates, but my scores are not changing, why is that?
If you are using the custom period, ensure that you are selecting 'custom period' as the value in the field 'period of interest'.
On the field PID 3.1 CK, If MiHIN does not assign a Common Key does it still count against me?
Common Key assignment from MiHIN, is not the same as Common Key in Conformance. PID 3.1 is measuring if there was a common key included in the message.
Why is PID-29 blank?

You either do not have PID-30 mapped, or you did not send messages for deceased patients during that time frame.

What is MiHIN expecting to see in PV1-37?
If there is a discharge location, such as a Skilled Nursing Facility, we are expecting the name of the facility they were discharged to be listed. If the patient was discharged home or to self, then "home", "self", or similar values would also be appropriate.

Do I need to map IN1-3 and IN1-4?
You can map these values; however, it is not required for conformance despite being listed in the mapping table. You must send the value, but do not need to map it even though it is in the mapping table. This conformance requirement was added as of 2021.
What is MiHIN expecting for PV1-19?
PV1-19 is expecting the Encounter or Visit Number.

What are the coding requirements for DG1-3.1 & DG1-3.2?
There must be a valid ICD-9 or ICD-10 code in DG1-3.1 & DG1-3.2.
I downloaded my ADT example; how do I open it?

	The file has a .hl7 extension meaning it needs to be opened using a Text Editor, like Notepad or Notepad++

What should we put as date/time of death if patient is dead on arrival?	
	You should put a default time 0000 in those cases.

Appendix B: Field Definitions

DG1-3.1: Diagnosis Code IDDG1-3.2: Diagnosis Code TextDG1-6: Diagnosis TypeIN1-3: Insurance Company IDIN1-4: Insurance Company NamePID-5.1: Patient Last NamePID-5.2: Patient First NamePID-7: Patient DOBPID-8: Patient SexPID-10: Patient RacePID-11.5: Patient ZIPPID-19: Patient SSNPID-22: Ethnic GroupPID-29: Patient Death Date/TimePID-30: Patient Death IndicatorPV1-2: Patient ClassPV1-4: Admission TypePV1-7: Attending Doctor IDPV1-10: Hospital ServicePV1-14: Admit SourcePV1-17: Admitting Doctor IDPV1-19: Visit NumberPV1-36: Discharge DispositionPV1-37: Discharge to LocationPV1-44: Admit Date/TimePV1-45: Discharge Date/Time

Appendix C: Glossary of Abbreviations and Acronyms

Acronym	Definition
ADT	An Admission, Discharge, Transfer message is used for trigger events such as hospital admissions, discharges and transfers and is used to exchange the patient's status within a facility.
CCD	Continuity of Care Document is a patient's clinical summary for electronic document exchange between providers, systems and/or facilities. Contained within a CCD is the most relevant demographic and clinical information about a patient in HL7 FHIR V3 (XML). This includes: Patient demographics, Patient history, Medications, Allergies, Procedures, Encounters, Problem lists, Immunizations, Lab results.
C-CDA	Consolidated Clinical Documentation Architecture

CKS	Common Key Service.
OIDs	Object Identifiers. An identifier mechanism standardized by the International Telecommunications Union (ITU) and ISO/IEC for naming any object, concept, or "thing" with a globally unambiguous persistent name.
ORU	Observation Result
URL	Uniform Resource Locator.
XML	Extensible Markup Language .
XPath	XML path language.