

HITSP Long Term and Post Acute Care Assessments Component

HITSP/C168



Healthcare Information Technology Standards Panel

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1.0 INTRODUCTION

1.1 OVERVIEW

The Healthcare Information Technology Standards Panel (HITSP) Long Term and Post Acute Care Assessments (LTPAC) Component describes how information contained in common long term and post acute care assessment tools are exchanged. LTPAC assessment information is helpful to clinicians, providers and others as part of a patient consultation or transfer of care.

1.2 COPYRIGHT PERMISSIONS

COPYRIGHT NOTICE

© 2010 ANSI. This material may be copied without permission from ANSI only if and to the extent that the text is not altered in any fashion and ANSI's copyright is clearly noted.

Certain materials contained in this Component are reproduced from the "CDA Representation of the Minimum Data Set Questionnaire Assessment (U.S. Realm) Based on HL7 CDA Release 2.0 Draft Standard for Trial Use Release 1.0 April 2009" with permission of Health Level Seven, Inc. No part of this material may be copied or reproduced in any form outside of the Component documents (including an electronic retrieval system or made available on the Internet), without the prior written permission of Health Level Seven, Inc. Copies of standards included in this Component may be purchased from the Health Level Seven, Inc. Material drawn from these standards is credited where used.

1.3 REFERENCE DOCUMENTS

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

Table 1-1 Reference Documents

Reference Document	Document Description
HITSP Acronyms List	Lists and defines the acronyms used in this document
HITSP Glossary	Provides definitions for relevant terms used by HITSP documents
TN900 - Security and Privacy	TN900 is a reference document that provides the overall context for use of the HITSP Security and Privacy constructs
TN901 - Clinical Documents	TN901 is a reference document that provides the overall context for use of the HITSP Care Management and Health Records constructs
TN903 - Data Architecture	TN903 is a reference document that provides the overall context for use of the HITSP Data Architecture constructs
TN904 - Harmonization Framework and Exchange Architecture	TN904 is a reference document that provides the overall context for use of the HITSP Harmonization Framework and Exchange Architecture

1.4 CONFORMANCE

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

1.4.1 CONFORMANCE CRITERIA

In order to claim conformance to this construct specification, an implementation must satisfy all the requirements and mandatory statements listed in this specification, the associated HITSP Interoperability Specification or Capability, its associated construct specifications, as well as conformance criteria from



the selected base and composite standards. A conformant system must also implement all of the required interfaces within the scope, subset or implementation option that is selected from the associated Interoperability Specification.

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

1.4.2 CONFORMANCE SCOPING, SUBSETTING AND OPTIONS

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



2.0 COMPONENT DEFINITION

A Component defines HITSP atomic constructs used to support an information exchange or to meet an infrastructure requirement. This is accomplished by:

- (a) Referencing one or more underlying standards
- (b) Specifying constraints and other rules for using the standards.

2.1 CONTEXT OVERVIEW

Long term, residential, and other post-acute care settings record patient information (such as clinical findings or condition, functional status, or care/treatments given) using uniform or “established” questionnaire-type assessments at admission, specific intervals, or at transfer/discharge. Each question and matched responses may be specifically defined and/or limited in scope. Some responses require a face-to-face interview. Some responses are gathered and summarized from multiple sources (such as clinical notes, laboratory findings, orders or flowsheets) within the medical record. Clinicians may use this type of information during a consultation or transfer of care from one setting or provider to another. A response may have meaning only within the context of its assessment, question and/or previous responses.

This Component describes the exchange of any standardized question/answer type assessment or assessment tool using the appropriate universal LOINC ® codes (as noted in the LOINC ® universal database). This Component also supports the local exchange of question/answer type assessments or assessment tools using local LOINC ® codes (specific terms, names, questions, responses, etc. mapped to LOINC ® codes) for agreed-upon use by specific companies, organizations or networks.

CMS has mandated the use of specific question-answer assessment tools in certain settings. These tools are:

- Long term care, Skilled nursing facility care—MDS1 3.0
- Home health care—OASIS-C
- Inpatient rehabilitation facility care—IRF-PAI

CMS uses this assessment data to calculate internal and publicly reported quality measures/indicators (using CMS-specific formulas), payment levels, and in pay-for-performance initiatives. Although each tool gathers similar patient information (such as ADL functional status, mood, or skin condition) each tool uses somewhat different and precise definitions. For this reason, information about a common bodily function, such as continence, can only be understood in the context of its use in the specific assessment tool, specific question, and specific response.

The LOINC ® universal database contains codes for each mandated assessment type, section headers, questions, and responses, such as MDS and OASIS, etc.

HITSP has chosen to use the “CDA Release 2: CDA Framework for Questionnaire Assessments (Universal Realm) and CDA Representation of the Minimum Data Set Questionnaire Assessment (U.S. Realm) Based on HL7 CDA Release 2.0 Implementation Guide.” The CDA Framework for Questionnaire Assessments (Universal Realm) is a guide for generic questionnaire assessment that is able to support any assessment tool. The CDA Representation of the Minimum Data Set Questionnaire Assessment (U.S. Realm) is a specific instance of an assessment tool based upon the CMS Minimum Data Set.

¹ MDS = Minimum Data Set



2.1.1 COMPONENT DEPENDENCIES

Table 2-1 Component Dependencies

Standard/HITSP Component	Depends On (Name of standard/HITSP Component that it depends on)	Dependency Type (Pre-condition, Post-condition, General)	Purpose (Reason for this dependency)
HITSP/C168 – Long Term and Post Acute Care Assessments	HITSP/C83 – CDA Content Modules	General	Defines the content modules

2.2 RULES FOR IMPLEMENTING

2.2.1 DATA MAPPING

C168-[CT1-1] Implementations of this Component **SHALL** support Implementation Guide for CDA Release 2: CDA Framework for Questionnaire Assessments (Universal Realm) and CDA Representation of the Minimum Data Set Questionnaire Assessment (U.S. Realm) Based on HL7 CDA Release 2.0 Draft Standard for Trial Use Release 1.0 April 2009.

C168-[CT1-2] A CDA Document **SHALL** declare conformance to this specification by including a **<templateId>** element with the root attribute one of the following values: (CDA Framework for Questionnaire Assessments) 2.16.840.1.113883.3.88.11.168.1 or (Long Term Care MDS 3.0 Assessments) 2.16.840.1.113883.3.88.11.168.2

2.2.1.1 CDA FRAMEWORK FOR QUESTIONNAIRE ASSESSMENTS (UNIVERSAL REALM)

The Questionnaire Assessments (universal realm) provide questionnaire assessments containing multiple questions with specific answers related to a variety of clinical domains. It does not require or define a specific assessment tool but some examples are OASIS-C, IRF-PAI, and other locally defined assessments. The CDA format follows the specification as defined in the CDA Release 2: CDA Framework for Questionnaire Assessments (Universal Realm).

The following table defines the HITSP constraints for the record. In no case are the HITSP constraints below less strict than those defined by HL7.

The template identifier for this is 2.16.840.1.113883.3.88.11.168.1

Table 2-2 CDA Framework for Questionnaire Assessments (Universal Realm) Content Modules

Constraint ID	Content Module	HITSP Optional Entry	HITSP Repeatable Entry	Specification Reference
C168-[CT2-1]	Person Information	R	N	See HITSP/C83 Section 2.2.2.1 Person Information
C168-[CT2-2]	Questionnaire Assessment	R	N	See HITSP/C83 Section 2.2.2.47 Questionnaire Assessment Section

Optionality = "R" for Required, "R2" for Required if Known or "O" for Optional, or "C" for Conditional. Repeatable = "Y" for Yes, "N" for No

2.2.1.2 LONG TERM CARE MDS 3.0 ASSESSMENTS

Long Term Care MDS 3.0 Assessments is a specific use of a questionnaire assessment (a federally mandated tool for use in all nursing homes to record patient status in a question/answer structure). The CDA format follows the specification as defined in the CDA Representation of the Minimum Data Set Questionnaire Assessment (U.S. Realm).

The following table defines the HITSP constraints for the record. In no case are the HITSP constraints below less strict than those defined by HL7.

The template identifier for this is 2.16.840.1.113883.3.88.11.168.2



Table 2-3 Long Term Care MDS 3.0 Assessments Content Modules

Constraint ID	Content Module	HITSP Optional Entry	HITSP Repeatable Entry	Specification Reference
C168-[CT3-1]	Person Information	R	N	See HITSP/C83 Section 2.2.2.1 Person Information
C168-[CT3-2]	Questionnaire Assessment	R	N	See HITSP/C83 Section 2.2.2.47 Questionnaire Assessment Section

Optionality = "R" for Required, "R2" for Required if Known or "O" for Optional, or "C" for Conditional. Repeatable = "Y" for Yes, "N" for No

2.3 STANDARDS

2.3.1 REGULATORY GUIDANCE

Table 2-4 Regulatory Guidance

Regulation	Description
No applicable regulations	

2.3.2 SELECTED STANDARDS

Table 2-5 Selected Standards

Standard	Description
Health Level Seven (HL7) HL7 Version 3 Standard: Clinical Document Architecture (CDA), Release 2	The HL7 Clinical Document Architecture is an XML-based document markup standard that specifies the structure and semantics of clinical documents for the purpose of exchange. CDA is one instantiation of HL7's Version 3.0 Reference Information Model (RIM) into a specific message format. Of particular focus for HITSP Interoperability Specifications are message formats for Laboratory Results and Continuity of Care (CCD) documents. Release 2 of the HL7 Clinical Document Architecture (CDA) is an extension to the original CDA document markup standard that specifies the structure and semantics of clinical documents for the purpose of exchange. CDA R2 includes a prose document in HTML, XML schemas, data dictionary, and sample CDA documents. CDA R2 further builds upon other HL7 standards beyond just the Version 3.0 Reference Information Model (RIM) and incorporates Version 3.0 Data Structures, Vocabulary, and the XML Implementation Technology Specifications for Data Types and Structures. For more information visit www.hl7.org
Implementation Guide for CDA Release 2: CDA Framework for Questionnaire Assessments (Universal Realm) and CDA Representation of the Minimum Data Set Questionnaire Assessment (U.S. Realm) Based on HL7 CDA Release 2.0 Draft Standard for Trial Use Release 1.0 April 2009	This draft standard specifies the CDA format to standardize the representation of Questionnaire Assessments (containing multiple questions with specific answers) for interoperable exchange. It identifies a generic "universal" framework and the representation of the MDS 3.0 (a Federally mandated tool for use in all nursing homes to record patient status in a question/answer structure) in CDA format. The CDA format allows interoperable-communication of patient information to other clinicians and healthcare facilities. For more information visit www.hl7.org

2.3.3 INFORMATIVE REFERENCE STANDARDS

Table 2-6 Informative Reference Standards

Standard	Reason for Use
LOINC ® and RELMA Users' Manuals	Contains information about the Logical Observation Identifiers Names and Codes (LOINC ®) and Regenstrief Institute's LOINC Mapping Assistant (RELMA ®). For more information visit http://loinc.org
MDS 3.0 data set specifications and manual	The Minimum Data Set (MDS) is a tool for implementing standardized assessment and for facilitating care management in nursing homes and non-critical access hospital swing beds. It contains information relating to this tool's purpose, use, structure, and item definition. For more information visit http://www.cms.hhs.gov/Nursinghomequalityinits/25_NHQIMDS30.asp



Standard	Reason for Use
§484.1 Basis and Scope §§1861(o) and 1891(a) of the Social Security Act (the Act) for HHA services §484.20(a) Standard: Encoding OASIS Data	The Outcome and Assessment Information Set (OASIS) is an instrument/data collection tool used to collect and report performance data by home health agencies. It contains information relating to this tool's purpose, use, structure, and item definition. For more information visit http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHOIOASISDataSet.asp
IRF-PAI data set specifications and manual	Inpatient Rehabilitation Facilities –Patient Assessment Instrument (IRF-PAI) is used to classify patients into distinct groups based on clinical characteristics and expected resource needs. It contains information relating to this tool's purpose, use, structure, and item definition. For more information visit http://www.cms.hhs.gov/InpatientRehabFacPPS/04_IRFPAI.asp



3.0 APPENDIX

No additional information at this time.



4.0 DOCUMENT UPDATES

This section provides the history of changes made to this document.

4.1 JANUARY 31, 2010

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

