July 8, 2009
Version 1.1

HITSP Consult and History & Physical Note Component

HITSP/C84

Submitted to:

Healthcare Information Technology Standards Panel

Submitted by:

Care Management and Health Records Domain Technical Committee

DOCUMENT CHANGE HISTORY

Version Number	Description of Change	Name of Author	Date Published
	Template V2.4	Project Team	July 31, 2008
0.0.1	Review Copy	Care Management and Health Records Domain Technical Committee	September 26, 2008
0.0.2	Review Copy	Care Management and Health Records Domain Technical Committee	December 10, 2008
1.0	Released for Implementation	Care Management and Health Records Domain Technical Committee	December 18, 2008
	Template V2.4	Project Team	June 30, 2009
1.0.1	Review Copy	Care Management and Health Records Domain Technical Committee	June 30, 2009
1.1	Released for Implementation	Care Management and Health Records Domain Technical Committee	July 8, 2009

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FIGURES AND TABLES

1.0 INTRODUCTION

1.1 OVERVIEW

The HITSP Consult and History & Physical Note Component supports two types of commonly used clinical notes, a consult note, and a history and physical note. It is intended for use to support the exchange of information from a consulting provider to a referring provider; and may also be used to provide background information from a referring provider to a consulting provider (e.g., prior reports). Patient encounter data are captured as part of the normal process of care performed by healthcare providers, such as hospitals, emergency departments and outpatient clinics.

1.2 COPYRIGHT PERMISSIONS

1.3 REFERENCE DOCUMENTS

This section provides a list of key reference documents and background material.

A list of key reference documents and background material is provided in the table below. These documents can be retrieved from www.hitsp.org.

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

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, 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 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 to claim conformance.

2.0 COMPONENT DEFINITION

2.1 CONTEXT OVERVIEW

This Component supports two types of commonly used clinical notes, a consult note, and a history and physical note. It is intended for use to support the exchange of information from a consulting provider to a referring provider; and may also be used to provide background information from a referring provider to a consulting provider (e.g., prior reports). This Component draws upon two closely related HL7 Implementation guides for these kinds of clinical notes.

The HL7 Health Level Seven (HL7) Implementation Guide for CDA Release 2: Consultation Note describes its purpose as:

The text for the HL7 specification begins here:

> This standard specifies constraints on CDA R2 for Consultation Notes. It re-uses section and entry-level templates created for CCD and for the History and Physical DSTU. For the purpose of this Implementation Guide, a consultation visit is defined by the evaluation and management guidelines for a consultation established by the Centers for Medicare and Medicaid Services (CMS). According to those guidelines, a Consultation Note must be generated as a result of a physician or non-physician practitioner's (NPP) request for an opinion or advice from another physician or NPP.
>
> Consultations must involve face-to-face time with the patient or fall under guidelines for telemedicine visits.
>
> A Consultation Note must be provided to the referring physician or NPP and must include the reason for the referral, history of present illness, physical examination, and decision-making component (assessment and plan).

The text for the HL7 specification ends here.

And, as stated in the Health Level Seven (HL7) Implementation Guide for CDA Release 2: History and Physical (H&P) Notes:

The text for the HL7 specification begins here:

> A History and Physical (H&P) Note is a two-part medical report which documents the current and past conditions of the patient. It contains both subjective and objective information and forms the basis of most treatment plans. The first half of the report includes subjective information, typically supplied by the patient or their caregiver, about the current medical problem or the reason for the patient encounter. This information is followed by a description of any past or ongoing medical issues, including current medications and allergies. Information is also obtained about the patient's lifestyle, habits, and diseases among family members.
>
> The second half of the report contains objective information obtained by physically examining the patient and gathering diagnostic information in the form of laboratory tests, imaging, or other diagnostic procedures. The report ends with the clinician's assessment of the patient's situation and the intended plan to address those issues. A History and Physical Examination is required upon hospital admission as well as before operative procedures. An initial evaluation in an ambulatory setting is often documented in the form of a History and Physical Note.

The text for the HL7 specification ends here.

2.1.1 COMPONENT CONSTRAINTS

Table 2-1 Component Constraints

Constraint	Constraint Section
No applicable constraints	

2.1.2 COMPONENT DEPENDENCIES

Table 2-2 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/C84 Consult and History & Physical Note	HITSP/C83 CDA Content Modules	General	Identifies Content Modules constrained by this Component to be applied within the exchange

2.2 RULES FOR IMPLEMENTING

The following section documents the content of the Component. It provides the basics elements and secondary standards that are supported by this Component and the constraints that are being placed on those standards. Specifically, it describes the subset or constraints that are required for this Component, and the minimum attributes of the Component as it relates to the base or composite standards on which it is based[1].

2.2.1 DATA MAPPING

This section describes the specific data elements used by this Component. Due to the potentially large number of data elements in a particular standard, only the fields that HITSP is constraining differently from the standard will be described here.

For all constraints applied to the data the reader must refer to:

- Health Level Seven (HL7) Implementation Guide for CDA Release 2: History and Physical (H&P) Notes
- Health Level Seven (HL7) Implementation Guide for CDA Release 2: Consultation Note
- The HITSP constraints defined in Table 2-3 and Table 2-4

The following sections describe the content modules for the Consultation and History and Physical.

2.2.1.1 CONSULTATION NOTE

C84-[CT1-20]	Implementations of this Component SHALL support the Consultation Note Content Modules as defined by Health Level Seven (HL7) Implementation Guide for CDA Release 2: Consultation Note. Implementation SHALL also support the HITSP constraints specified in Table 2-3
C84-[CT1-21]	Implementations of this Component SHALL use the document type code: 11488-4 Consultation Note
C84-[CT1-22]	Implementations of this Component SHALL contain a structuredBody element
C84-[CT1-23]	inFulfillmentOf/order/id SHALL contain the order identifier of the referring physician referral request order

[1] We have added template identifiers to the document specifications that follow. These template identifiers are recommended be used in exchanges, but are not required due to restrictions on major change. It is possible that these identifiers could be required in future editions of this specification

The template identifier for this 2.16.840.1.113883.3.88.11.84.1.

Table 2-3 Consultation Note Content Modules

Constraint ID	Content Module	HITSP Optional Entry[2]	HITSP Repeatable Entry[3]	Specification Reference
C84-[CT1-1]	Active Problems	R	N	See HITSP/C83 Section 2.2.1.3 Problem List Section
C84-[CT1-2]	Advance Directives	R	N	See HITSP/C83 Section 2.2.1.16 Advance Directives Section
C84-[CT1-3]	Allergies	R	N	See HITSP/C83 Section 2.2.1.2 Allergies and Other Adverse Reactions Section
C84--[CT1-4]	Current Meds	R	N	See HITSP/C83 Section 2.2.1.12 Medications Section
C84--[CT1-5]	Family History	R2	N	See HITSP/C83 Section 2.2.1.25 Family History Section
C84--[CT1-6]	Functional Status	R2	N	See HITSP/C83 Section 2.2.1.9 Functional Status Section
C84--[CT1-7]	History Present Illness	R	N	See HITSP/C83 Section 2.2.1.7 History of Present Illness Section
C84--[CT1-8]	Immunizations	R2	N	See HITSP/C83 Section 2.2.1.17 Immunizations Section
C84--[CT1-9]	List of Surgeries	R2	N	See HITSP/C83 Section 2.2.1.8 List of Surgeries Section
C84--[CT1-10]	Person Information	R	N	See HITSP/C83 Section 2.2.2.1 Personal Information
C84--[CT1-11]	Pertinent Insurance Information	R2	N	See HITSP/C83 Section 2.2.1.1 Payers Section
C84--[CT1-12]	Physical Exam	R2	N	See HITSP/C83 Section 2.2.1.18 Physical Examination Section
C84--[CT1-13]	Plan of Care	R	N	See HITSP/C83 Section 2.2.1.24 Plan of Care Section
C84--[CT1-14]	Reason for Referral	R	N	See HITSP/C83 Section 2.2.1.6 Reason for Referral Section
C84--[CT1-15]	Relevant Diagnostic Surgical Procedures/Clinical Reports and Relevant Diagnostic Test and Reports	R2	N	See HITSP/C83 Section 2.2.1.22 Diagnostic Results Section
C84--[CT1-16]	Resolved Problems	R2	N	See HITSP/C83 Section 2.2.1.4 History of Past Illness Section
C84--[CT1-17]	Review of Systems	O	N	See HITSP/C83 Section 2.2.1.20 Review of Systems Section
C84--[CT1-18]	Social History	R2	N	See HITSP/C83 Section 2.2.1.26 Social History Section
C84--[CT1-19]	Vital Signs	R2	N	See HITSP/C83 Section 2.2.1.19 Vital Signs Section

2.2.1.2 HISTORY AND PHYSICAL

C84-[CT2-16] Implementations of this Component **SHALL** support the History and Physical Content Modules as defined by Health Level Seven (HL7) Implementation Guide for CDA Release 2: History and Physical (H&P) Notes. Implementation shall also support the HITSP constraints specified in Table 2-4.

C84-[CT2-17] Implementations of this Component **SHALL** use the document type code: 34117-2 History & Physical

C84-[CT2-18] Implementations of this Component **SHALL** contain a structuredBody element

C84-[CT2-19] When used to respond to a request for consultation, the inFulfillmentOf/order/id **SHALL** contain the order identifier of the referring physician referral request order

The template identifier for this 2.16.840.1.113883.3.88.11.84.2.

[2] Optionality **=** "R" for Required, "R2" for Required if Known or "O" for Optional, or "C" for Conditional. Repeatable = "Y" for yes, "N" for No.

[3] See HITSP/C83 for information regarding the repeatability of Data Elements with a Section.

Table 2-4 History and Physical Content Modules

Constraint ID	Content Module	HITSP Optional Entry[4]	HITSP Repeatable Entry[5]	Specification Reference
[C84-[CT2-1]	Allergies	R	N	See HITSP/C83 Section 2.2.1.2 Allergies and Other Adverse Reactions Section
[C84-[CT2-2]	Assessment and Plan	R	N	See HITSP/C83 Section 2.2.1.23 Assessment and Plan Section
[C84-[CT2-3]	Chief Complaint	R	N	See HITSP/C83 Section 2.2.1.5 Chief Complaint Section
[C84-[CT2-4]	Current Meds	R	N	See HITSP/C83 Section 2.2.1.12 Medications Section
[C84-[CT2-5]	Family History	R	N	See HITSP/C83 Section 2.2.1.25 Family History Section
[C84-[CT2-6]	History Present Illness	R	N	See HITSP/C83 Section 2.2.1.7 History of Present Illness Section
[C84-[CT2-7]	Immunization History	O	N	See HITSP/C83 Section 2.2.1.17 Immunizations Section
[C84-[CT2-8]	Person Information	R	N	See HITSP/C83 Section 2.2.2.1 Personal Information
[C84-[CT2-9]	Physical Examination	R	N	See HITSP/C83 Section 2.2.1.18 Physical Examination Section
[C84-[CT2-10]	Problems	R	N	See HITSP/C83 Section 2.2.1.3 Problem List Section
[C84-[CT2-11]	Procedure History	O	N	See HITSP/C83 Section 2.2.1.8 List of Surgeries Section
[C84-[CT2-12]	Relevant Diagnostic Surgical Procedures/Clinical Reports and Relevant Diagnostic Test and Reports	R	N	See HITSP/C83 Section 2.2.1.22 Diagnostic Results Section
[C84-[CT2-13]	Resolved Problems	R	N	See HITSP/C83 Section 2.2.1.4 History of Past Illness Section
[C84-[CT2-14]	Review of Systems	R	N	See HITSP/C83 Section 2.2.1.20 Review of Systems Section
[C84-[CT2-15]	Social History	R	N	See HITSP/C83 Section 2.2.1.26 Social History Section

Guidelines and Examples

Examples of these documents may be found via the following links:

- Consult Notes: www.hl7.org/dstucomments/showdetail.cfm?dstuid=24
- History and Physical Notes: www.hl7.org/dstucomments/showdetail.cfm?dstuid=25

[4] Optionality **=** "R" for Required, "R2" for Required if Known or "O" for Optional, or "C" for Conditional. Repeatable = "Y" for yes, "N" for No.

[5] See HITSP/C83 for information regarding the repeatability of Data Elements with a Section.

2.3 STANDARDS

2.3.1 REGULATORY GUIDANCE

Table 2-5 Regulatory Guidance

Standard	Description
No applicable regulatory guidance	

2.3.2 SELECTED STANDARDS

Table 2-6 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 2.0 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
Health Level Seven (HL7) Implementation Guide for CDA Release 2.0: Consultation Note	The HL7 Implementation Guide for CDA Release 2.0: Consultation Note defines additional constraints on the CDA Header and Body used in a Consultation document in the U.S. realm, and provides examples of conforming fragments in the body of the document and an example of a conforming XML instance. For more information visit www.hl7.org
Health Level Seven (HL7) Implementation Guide for CDA Release 2.0: History and Physical (H&P) Notes	The HL7 Implementation Guide for CDA Release 2.0: History and Physical (H&P) Notes defines additional constraints on the CDA Header and Body used in a History and Physical document in the U.S. realm, and provides examples of conforming fragments in the body of the document and an example of a conforming XML instance. For more information visit www.hl7.org

2.3.3 INFORMATIVE REFERENCE STANDARDS

Table 2-7 Informative Reference Standards

Standard	Description
Health Level Seven (HL7) Implementation Guide: CDA Release 2 – Continuity of Care Document (CCD), April 01, 2007	The Continuity of Care Document implementation guide describes constraints on the HL7 Clinical Document Architecture, Release 2 (CDA) specification in accordance with requirements set forward in ASTM E2369-05 Standard Specification for Continuity of Care Record (CCR). The resulting specification, known as the Continuity of Care Document (CCD), is developed as a collaborative effort between ASTM and HL7. It is intended as an alternate implementation to the one specified in ASTM ADJE2369 for those institutions or organizations committed to implementation of the HL7 Clinical Document Architecture. For more information visit www.hl7.org

3.0 APPENDIX

The following sections include relevant materials referenced throughout this document.

- A listing of all HITSP Constraints defined within this document.
- A listing of all HITSP Template identifiers defined within this document.

3.1 HITSP CONSTRAINTS DEFINED IN THIS DOCUMENT

C84-[CT1-20]	Implementations of this Component SHALL support the Consultation Note Content Modules as defined by Health Level Seven (HL7) Implementation Guide for CDA Release 2: Consultation Note. Implementation SHALL also support the HITSP constraints specified in Table 2-3
C84-[CT1-21]	Implementations of this Component SHALL use the document type code: 11488-4 Consultation Note
C84-[CT1-22]	Implementations of this Component SHALL contain a structuredBody element
C84-[CT1-23]	inFulfillmentOf/order/id SHALL contain the order identifier of the referring physician referral request order
C84-[CT2-16]	Implementations of this Component **SHALL** support the History and Physical Content Modules as defined by Health Level Seven (HL7) Implementation Guide for CDA Release 2: History and Physical (H&P) Notes. Implementation shall also support the HITSP constraints specified in Table 2-4.
C84-[CT2-17]	Implementations of this Component **SHALL** use the document type code: 34117-2 History & Physical
C84-[CT2-18]	Implementations of this Component **SHALL** contain a structuredBody element
C84-[CT2-19]	When used to respond to a request for consultation, the inFulfillmentOf/order/id **SHALL** contain the order identifier of the referring physician referral request order

C84-[CT1-1]	See HITSP/C83 Section 2.2.1.3 Problem List Section
C84-[CT1-2]	See HITSP/C83 Section 2.2.1.16 Advance Directives Section
C84-[CT1-3]	See HITSP/C83 Section 2.2.1.2 Allergies and Other Adverse Reactions Section
C84--[CT1-4]	See HITSP/C83 Section 2.2.1.12 Medications Section
C84--[CT1-5]	See HITSP/C83 Section 2.2.1.25 Family History Section
C84--[CT1-6]	See HITSP/C83 Section 2.2.1.9 Functional Status Section
C84--[CT1-7]	See HITSP/C83 Section 2.2.1.7 History of Present Illness Section
C84--[CT1-8]	See HITSP/C83 Section 2.2.1.17 Immunizations Section
C84--[CT1-9]	See HITSP/C83 Section 2.2.1.8 List of Surgeries Section
C84--[CT1-10]	See HITSP/C83 Section 2.2.2.1 Personal Information
C84--[CT1-11]	See HITSP/C83 Section 2.2.1.1 Payers Section
C84--[CT1-12]	See HITSP/C83 Section 2.2.1.18 Physical Examination Section
C84--[CT1-13]	See HITSP/C83 Section 2.2.1.24 Plan of Care Section
C84--[CT1-14]	See HITSP/C83 Section 2.2.1.6 Reason for Referral Section
C84--[CT1-15]	See HITSP/C83 Section 2.2.1.22 Diagnostic Results Section
C84--[CT1-16]	See HITSP/C83 Section 2.2.1.4 History of Past Illness Section
C84--[CT1-17]	See HITSP/C83 Section 2.2.1.20 Review of Systems Section
C84--[CT1-18]	See HITSP/C83 Section 2.2.1.26 Social History Section
C84--[CT1-19]	See HITSP/C83 Section 2.2.1.19 Vital Signs Section
[C84-[CT2-1]	See HITSP/C83 Section 2.2.1.2 Allergies and Other Adverse Reactions Section
[C84-[CT2-2]	See HITSP/C83 Section 2.2.1.23 Assessment and Plan Section
[C84-[CT2-3]	See HITSP/C83 Section 2.2.1.5 Chief Complaint Section

[C84-[CT2-4] See HITSP/C83 Section 2.2.1.12 Medications Section
[C84-[CT2-5] See HITSP/C83 Section 2.2.1.25 Family History Section
[C84-[CT2-6] See HITSP/C83 Section 2.2.1.7 History of Present Illness Section
[C84-[CT2-7] See HITSP/C83 Section 2.2.1.17 Immunizations Section
[C84-[CT2-8] See HITSP/C83 Section 2.2.2.1 Personal Information
[C84-[CT2-9] See HITSP/C83 Section 2.2.1.18 Physical Examination Section
[C84-[CT2-10] See HITSP/C83 Section 2.2.1.3 Problem List Section
[C84-[CT2-11] See HITSP/C83 Section 2.2.1.8 List of Surgeries Section
[C84-[CT2-12] See HITSP/C83 Section 2.2.1.22 Diagnostic Results Section
[C84-[CT2-13] See HITSP/C83 Section 2.2.1.4 History of Past Illness Section
[C84-[CT2-14] See HITSP/C83 Section 2.2.1.20 Review of Systems Section
[C84-[CT2-15] See HITSP/C83 Section 2.2.1.26 Social History Section

3.2 TEMPLATE IDENTIFIERS

- 2.16.840.1.113883.3.88.11.84.1 HITSP/C84 Consultation Note
- 2.16.840.1.113883.3.88.11.84.2 HITSP/C84 History and Physical Note

4.0 DOCUMENT UPDATES

The following sections provide the details of updates made to this document.

4.1 DECEMBER 10, 2008

The changes in this cycle address the following comments received during the September 29th through October 24th, 2008 public review and comment period.

No comments were received.

Minor editorial changes were made to this document.

4.1.1 SECTION 2.2.1 DATA MAPPING

- Added clarification as to where the reader should go to find all constraints applied to the data.
- Expanded the Note for Table 2-3 and Table 2-4 to define the values used in the Repeatable Entry column.

4.2 DECEMBER 18, 2008

Upon approval by the HITSP Panel on December 18, 2008, this document is now Released for Implementation.

4.3 JUNE 30, 2009

Revised the document based on HITSP/TN903 Data Architecture

4.3.1 GENERAL UPDATES

- Section 2.2 Rules for Implementing: Addition of Note on usage of HITSP Constraints
- Section 2.2.1 Data Mapping: Added Template Identifiers to Consultation Note, and History and Physical Note. Added Constraint IDs to identify all HITSP Constraints
- Section 3.0 Appendix: Added links to all HITSP/C84 Encounter Data Elements and HITSP Constraints

The changes in this construct address the following comments received via the HITSP comment tracking system.

- 7071, 7078

The full text of the comments along with the Technical Committee's disposition can be reviewed on the HITSP Public Web Site.

Minor editorial changes were made to this construct. Removed boilerplate text for simplification. The term "actor" was replaced with "interface".

4.4 JULY 8, 2009

Upon approval by the HITSP Panel on July 8, 2009, this document is now Released for Implementation.