

HITSP Case Report Pre-Populate Component

HITSP/C76



Healthcare Information Technology Standards Panel

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1.0 INTRODUCTION

1.1 OVERVIEW

The HITSP Case Report Pre-Populate Component supports the Data Mapping needed for Public Health Case Reports including:

- Drug Safety
- Device Safety
- Drug Administration Management
- Vaccine Adverse Event Report
- Food Safety
- Reportable Disease Reports
- Healthcare Associated Infection
- Other Healthcare safety reports other than Infection (e.g. falls) (including sentinel events; all never-events, anything that may become a never-event; AHRQ)

This Component addresses pre-populating a form supported by HITSP/TP50 Retrieve Form for Data Capture. It supports only those data attributes that are universal or that pertain to drug safety reporting. For those attributes that are available in a CDA document this Component may be used in support of pre-populating the report. For those attributes that are universal for case reporting but not available in a CDA document refer to the Interoperability Specification for any further information or specific constraints. Other public health specific attributes will be addressed in subsequent releases.

1.2 COPYRIGHT PERMISSIONS

COPYRIGHT NOTICE

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IHE materials used in this document have been extracted from relevant copyrighted materials with permission of Integrating the Healthcare Enterprise (IHE). Copies of this standard may be retrieved from the IHE Website at www.ihe.net.

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



Reference Document	Document Description
TN900 - Security and Privacy	TN900 is a reference document to provide the overall context for use of the HITSP Security and Privacy constructs
TN901 - Clinical Documents	TN901 is a reference document to provide 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 a standard set of data, terminology constraints, and associated mapping to EHR elements for pre-population within a Form Filler to optimize data capture from EHR for use in Public Health Case Reporting. This includes support for:

- Drug Safety
- Device Safety
- Drug Administration Management
- Vaccine Adverse Event
- Food Safety
- Reportable Disease
- Healthcare Associated Infection
- Other Health Case Safety Reports other than Infection (e.g. falls) including Sentinel events; all never-events, anything that may become a never-event; AHRQ

See Table 2-1 for common and domain specific data elements for pre-population mapping.

2.1.1 COMPONENT CONSTRAINTS

Table 2-1 Component Constraints

Constraint	Constraint Section
This Component is applicable to those attributes that universally support all case reporting and those attributes that are specific to drug safety reporting	2.2.1

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/C76 Case Report Pre-Populate	HITSP/C80 Clinical Document and Message Terminology	General	Vocabulary constraints for non-laboratory attributes except as specified by this Component
HITSP/C76 Case Report Pre-Populate	HITSP/C83 CDA Content Modules	General	Identifies Content Modules Data Elements constrained by this Component to be applied within the exchange
HITSP/C76 Case Report Pre-Populate	HITSP/C35 Lab Result Terminology	General	Vocabulary constraints for laboratory attributes except as specified by this Component

2.2 RULES FOR IMPLEMENTING

2.2.1 DATA MAPPING

Except as noted below, all data mapping constraints shall be as indicated in the Integrating the Healthcare Enterprise (IHE) Drug Safety Profile (DSP), Volume II Specification, leveraging the vocabulary constraints as identified by HITSP/C80 Clinical Document and Message Terminology.



Table 2-3 Data Mapping

Data Element	Description	Limit/Range of values	Data Source	Optionality ¹	Additional Specification for Component
Address	The address (Street, City, State, Zip Code) of the person or facility that diagnosed the subject of the case report	The State Component shall be coded as specified in HITSP/C80 Section 2.2.1.1.1 State		R	This data element comes from the submitting system and is not derived from a CDA document providing details about clinical care
Administration of Treatment	Was treatment administered?			R	See HITSP/C83 Section 2.2.2.8 Medication, 2.2.2.17 Procedure, and 2.2.2.13 Immunization
Admission Date	Enter the date that the subject of the case report was admitted to the hospital			O	See HITSP/C83 Section 2.2.1.10 Hospital Admission Diagnosis and 2.2.2.7 Conditions
Age	The age of the subject of the case report at the time of diagnosis			O	See HITSP/C83 Section 2.2.2.7 History of Present Illness Section, Data Element 7.06 Age (at Onset)
Birth Weight	The weight of the patient at birth	Shall be coded as specified in HITSP/C80 Section 2.2.3.6.6 Units of Measures		O	See HITSP/C83 Section 2.2.2.15 Results, Data Element 15.05 Result Value
Common Device Name	Common name of the device			O	See HITSP/C83 Section 2.2.2.6 Allergy/Drug Sensitivity, Data Element 6.03 Product Free-Text
Concomitant Medical Product Name	Other medical products in use for the patient to determine proximal relationships			O	See HITSP/C83 Section 2.2.2.8 Medication, Data Element 8.15 Free Text Product Name
Contact Person	The name of the person to be contacted for further information			O	This data element comes from the submitting system and is not derived from a CDA document providing details about clinical care
Contact Phone Number	The telephone number for the contact person			O	This data element comes from the submitting system and is not derived from a CDA document providing details about clinical care
Current Medications (Medwatch concomitant meds)	Other medications in use	Shall be coded as specified in HITSP/C80 Section 2.2.3.3.7 Medication Brand Name		O	See HITSP/C83 Section 2.2.2.8 Medication
Date of Administration of Treatment	The date treatment was administered. For HepB, date HBV vaccine administered			R	See HITSP/C83 Section 2.2.2.8 Medication, 2.2.2.17 Procedure, and 2.2.2.13 Immunization
Date of Birth	Date of birth			O	See HITSP/C83 Section 2.2.2.1 Personal Information, Data Element 1.07 Person Date of Birth

¹ Optionality = "R" for Required, "R2" for Required if Known or "O" for Optional, or "C" for Conditional.



Data Element	Description	Limit/Range of values	Data Source	Optionality ¹	Additional Specification for Component
Date of Death	If patient has died, deceased date/time			O	See HITSP/C83 Section 2.2.2.7 History of Present Illness Section, Data Element 7.08 Age (at Death)
Date of Event	The date the event first occurred			O	See HITSP/C83 Section 2.2.2.7 History of Present Illness Section, Data Element 7.01 Problem Date
Date Report Sent	The date the report is submitted			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Date Sent to FDA	The date the report was submitted to the FDA – U.S.			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Date User Facility/Importer Became Aware of Event	The date the event was first recognized by an observer			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Death	Did the subject die as a result of the disease?			R	See HITSP/C83 Section 2.2.2.7 History of Present Illness Section, Data Element 7.07 Cause of Death
Description of Event	A textual description of the event			R	See HITSP/C83 Section 2.2.2.7 History of Present Illness Section, Data Element 7.03 Problem Name
Diagnosis Type	Type of diagnosis being sent (admitting, working, final)	Shall be coded as specified in HITSP/C80 Section 2.2.3.1.3 Diagnosis Type		O	See HITSP/C83 Section 2.2.2.7 History of Present Illness Section, Data Element 7.02 Problem Type
Diagnosis/ Injury Code	Diagnosis or Diagnosis assigned as a result of the encounter	Shall be coded as specified in HITSP/C80 Section 2.2.3.1.1 Problem		O	See HITSP/C83 Section 2.2.2.7 History of Present Illness Section, Data Element 7.04 Problem Code
Discharge Date	Enter the date that the subject of the case report was Discharged from the hospital			R	See HITSP/C83 Section 2.2.1.11 Discharge Diagnosis and 2.2.2.7 Conditions
Estimated Deliver Date	Estimated date of delivery (or est. date of confinement [EDC])			O	See HITSP/C83 Section 2.2.2.15 Results, Data Element 15.05 Result Value
Ethnicity	The ethnicity of the subject of the case report	Shall be coded as specified in HITSP/C80 Section 2.2.1.2.2 Ethnicity		O	See HITSP/C83 Section 2.2.2.1 Personal Information, Data Element 1.11 Ethnicity



Data Element	Description	Limit/Range of values	Data Source	Optionality ¹	Additional Specification for Component
Event Patient Problem Code	The locally determined code to identify the problem for subsequent follow up	Shall be coded as specified in HITSP/C80 Section 2.2.3.1.1 Problem		R	See HITSP/C83 Section 2.2.2.7 Conditions, Data Element 7.04 Problem Code
Facility Identifier	Unique facility identifier			O	This data element comes from the submitting system and is not derived from a CDA document providing details about clinical care
Facility/ Importer Name	The name of the facility where the healthcare provider diagnosed the subject of the case report			R	This data element comes from the submitting system and is not derived from a CDA document providing details about clinical care
Gender	Patient sex			O	See HITSP/C83 Section 2.2.2.1 Personal Information, Data Element 1.06 Gender
Name of Condition	The name of the condition diagnosed for the subject of the case report			O	See HITSP/C83 Section 2.2.2.7 Conditions Data Element 7.03 Problem Name
Name of Treatment	Name of the treatment			R	See HITSP/C83 Section 2.2.2.8 Medication, 2.2.2.17 Procedure, and 2.2.2.13 Immunization
NDC# or Unique ID	The unique identifier for the product	Shall be coded as specified in HITSP/C80 Section 2.2.3.3.10 Medication Packaged Product		O	See HITSP/C83 Section 2.2.2.8 Medication, Data Element 8.13 Coded Product Name
Number of Siblings	The number of siblings in a multiple birth			O	See HITSP/C83 Section 2.2.2.15 Result, Data Element 15.05 Result Value
Occupation of Reporter	The role of the reporter (e.g., physician, nurse, administrator, etc.)			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Patient Address (street name, city, state, zip code)	The address of the subject of the case report	The State Component shall be coded as specified in HITSP/C80 Section 2.2.1.1.1 State		O	See HITSP/C83 Section 2.2.2.1. Personal Information, Data Element 1.03 Person Address
Patient Alias Name: First, Middle, Last	This field contains names by which the patient has been known at some time			O	See HITSP/C83 Section 2.2.2.1 Personal Information, Data Element 1.05 Person Name



Data Element	Description	Limit/Range of values	Data Source	Optionality ¹	Additional Specification for Component
Patient Class	General type of patient, e.g., Inpatient, Outpatient, Emergency	Shall be coded as specified in HITSP/C80 Section 2.2.3.9.5.2V3 Patient Class		O	See HITSP/C83 Section 2.2.2.16 Encounter, Data Element 16.02 Encounter Type
Patient Country	The country of the address of the subject of the case report	The Country Component shall be coded as specified in HITSP/C80 Section 2.2.1.1.3 Country		O	See HITSP/C83 Section 2.2.2.1 Personal Information, Data Element 1.03 Person Address
Patient County	The county of the address of the subject of the case report			O	See HITSP/C83 Section 2.2.2.1 Personal Information, Data Element 1.03 Person Address
Patient Identifier	The identifier for the patient, may be a pseudonymized identifier			R	See HITSP/C83 Section 2.2.2.1 Personal Information, Data Element 1.02 Person ID
Patient Name (First, MI, Last)	The name (preferably legal) of the subject of the case report			O	See HITSP/C83 Section 2.2.2.1 Personal Information, Data Element 1.05 Person Name
Patient Telephone	The telephone of the subject of the case report			O	See HITSP/C83 Section 2.2.2.1 Personal Information, Element 1.04 Person Phone/Email/URL
Pre-existing clinician diagnosed allergies, birth defects	Allergies, conditions existing prior to the use of the suspected agent	Shall be coded as specified in HITSP/C80 Section 2.2.3.4.1 Allergy/Adverse Event (Reaction)		O	See HITSP/C83 Section 2.2.2.6 Allergy/Drug Sensitivity and Section 2.2.2.7 Condition
Pregnancy Status	Whether the subject of the case report was pregnant at time of diagnosis			O	See HITSP/C83 Section 2.2.2.9 Pregnancy, Data Element 9.01 Pregnancy
Previous Vaccine Date Given	The date the vaccination dose suspected was administered			O	See HITSP/C83 Section 2.2.2.8 Medication, Data Element 8.03 Administration Timing
Previous Vaccine Lot #	The lot number of the vaccine dose			O	See HITSP/C83 Section 2.2.2.13 Immunization, Data Element 13.09 Lot Number
Previous Vaccine Manufacturer	The manufacturer of the vaccine dose	Shall be coded as specified in HITSP/C80 Section 2.2.3.5.12 Vaccine Manufacturer		O	See HITSP/C83 Section 2.2.2.13 Immunization, Data Element 13.08 Drug Manufacturer



Data Element	Description	Limit/Range of values	Data Source	Optionality ¹	Additional Specification for Component
Previous Vaccine Route	The route of administration of the vaccine dose	Shall be coded as specified in HITSP/C80 Section 2.2.3.3.4.1 Medication Route FDA		O	See HITSP/C83 Section 2.2.2.8 Medication, Data Element 8.07 Route
Previous Vaccine Type	The type of vaccine	Shall be coded as specified in HITSP/C80 Section 2.2.3.5.1 Vaccine Administered		O	See HITSP/C83 Section 2.2.2.13 Immunization, Data Element 13.06 Coded Product Name
Product Dose	The dose of the product administered	The Units shall be coded as specified in HITSP/C80 Section 2.2.3.6.6 Units of Measurement		O	See HITSP/C83 Section 2.2.2.8 Medication, Data Element 8.08 Dose
Product Frequency	The frequency with which the product was administered			O	See HITSP/C83 Section 2.2.2.8 Medication, Data Element 8.04 Frequency
Product Route Used	The route of administration of the product (e.g., oral, intravenous, intramuscular, etc.)	The Units shall be coded as specified in HITSP/C80 Section 2.2.3.3.4.1 Medication Route FDA		O	See HITSP/C83 Section 2.2.2.8 Data Element 8.07 Route
Product Therapy Dates	Duration of therapy with the product			O	See HITSP/C83 Section 2.2.2.8 Medication, Data Element 8.03 Administration Timing
Race	The race(s) of the subject of the case report	Shall be coded as specified in HITSP/C80 Section 2.2.1.2.7 Race		O	See HITSP/C83 Section 2.2.2.1 Personal Information, Data Element 1.10 Race
Report Date	The date that the case report is being sent			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Report Date/Time	Date/time of report	See HITSP/C35		O	See HITSP/C83 Section 2.2.2.15 Result, Data Element 15.02 Result Date/Time
Report sent to	The organization to which the report is submitted			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care



Data Element	Description	Limit/Range of values	Data Source	Optionality ¹	Additional Specification for Component
Report sent to FDA	Indication if the report is submitted to the Food and Drug Administration (FDA) – U.S.	Y/N/U		O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Report Source	The originator of the report			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Reported Previously	Indication if the information is supplemental to update in event already reported	Y/N/U		O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Reporter Address (street name, city, state, zip code)	The address of the reporter			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Reporter Email	The email contact information for the reporter			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Reporter Name	The name of the person or facility sending the case report			R	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Responsible physician/ Health care provider name	The name of the person that diagnosed the subject			O	This data element comes from the submitting system and is not derived from a CDA document providing details about clinical care
Result Unit	Unit for numeric result context	See HITSP/C35		O	See HITSP/C83 Section 2.2.2.15 Result, Data Element 15.05 Result Value
Resulted Test	The identifier code for the specific test Component resulted	See HITSP/C35		O	See HITSP/C83 Section 2.2.2.15 Result, Data Element 15.03 Result Type
Results Status	Status of report (preliminary, final, corrected)	See HITSP/C35		O	See HITSP/C83 Section 2.2.2.15 Result, Data Element 15.04 Result Status
Signs and Symptoms	The signs and symptoms experienced by the patient	Shall be coded as specified in HITSP/C80 Section 2.2.3.1.1 Problem		O	See HITSP/C83 Section 2.2.1.4 Chief Complaint, 2.2.1.6 Reason for Referral, 2.2.1.7 History of Present Illness, 2.2.1.10 Hospital Admission Diagnosis, 2.2.1.18 Physical Examination, 2.2.1.20 Review of Symptoms, and 2.2.2.7 Conditions
Suspect Medical Device Brand Name	Brand name of the suspect device			O	See HITSP/C83 Section 2.2.2.6 Data Element 6.03 Product Free-Text



Data Element	Description	Limit/Range of values	Data Source	Optionality ¹	Additional Specification for Component
Suspect Product Name	Product name	Shall be coded as specified in HITSP/C80 Section 2.2.3.3.7 Medication Brand Name or 2.2.3.3.10 Medication Packaged Product		O	See HITSP/C83 Section 2.2.2.8 Medications, Data Element 8.13 Coded Product Name
Symptom/ Illness Onset Date/Time	This is the range of time of which the problem was active for the patient; for PH: The date that the subject began having symptoms of condition being reported			O	See HITSP/C83 Section 2.2.2.7 Condition, Data Element 7.01 Problem Date
Telephone	The phone number of the person or facility that diagnosed the subject of the case report			O	This data element comes from the submitting system and is not derived from a CDA document providing details about clinical care
Telephone	The phone number of the person or facility sending the case report			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Test Interpretation	Interpretation of test result, including the susceptibility test interpretation	See HITSP/C35		O	See HITSP/C83 Section 2.2.2.15 Result, Data Element 15.06 Result Interpretation
Test Method	Testing method used to arrive at the specific result; the name of the laboratory test	See HITSP/C35		O	See HITSP/C83 Section 2.2.2.15 Result, Data Element 15.03 Result Type
Test Result	The test result of the laboratory test including any applicable result units of measure	See HITSP/C35		O	See HITSP/C83 Section 2.2.2.15 Result, Data Element 15.05 Result Value
Test Status	Status of the test result	See HITSP/C35		O	See HITSP/C83 Section 2.2.2.15 Result, Data Element 15.04 Result Status
Therapy Dates	Dates of treatment with the suspected agent			O	See HITSP/C83 Section 2.2.2.8 Medication, Data Element 8.03 Administration Timing
Type of Event and/or Issue	Characterization of the nature of the adverse event, product problem, product use error, or safety problem.			O	See HITSP/C83 Section 2.2.2.7 Condition, Data Element 7.02 Problem Type
Type of Report	The type of report (e.g., Drug Event Report, Healthcare Associated Infection Report, etc.)			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care



Data Element	Description	Limit/Range of values	Data Source	Optionality ¹	Additional Specification for Component
Type of Reporter	The role of the reporter with respect to the patient (e.g., treating or consulting clinician, case manager, nurse, etc.)			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
User Facility/Importer Report Number	The number of the report assigned by the reporting facility			O	This data element provides metadata about the document or message being sent and is not derived from a CDA document providing details about clinical care
Weight	The weight of the patient at the time of the report	Shall be coded as specified in HITSP/C80 Section 2.2.3.6.6 Units of Measurements		O	See HITSP/C83 Section 2.2.2.15 Result, Data Element 15.05 Result Value

2.3 STANDARDS

2.3.1 REGULATORY GUIDANCE

Table 2-4 Regulatory Guidance

Regulation	Description
No applicable regulatory guidance	

2.3.2 SELECTED STANDARDS

Table 2-5 Selected Standards

Standard	Description
Health Level Seven (HL7) Version 2.5.1	The HL7 Version 2.5.1 Messaging Standard is an application protocol for electronic data exchange in healthcare. It and prior versions have widespread use in the U.S. and internationally. Both message formats and value sets / code tables (e.g., diagnosis type, gender, patient class, result status, specimen collection method, abnormal flags, observation result status codes interpretation, timestamp format) are contained in the standard. Of particular focus for HITSP Interoperability Specifications are message formats described in Chapters 2, 3, 4, 5, and 7 including patient demographic (ADT), and lab result reporting. These are also used within composite standards from IHE for Patient Identity Cross-Referencing and Feed (PIX), Patient Demographics Query (PDQ) and Acknowledgements. They are also used in HL7 order messages. For more information visit www.hl7.org
Health Level Seven (HL7) Version 3.0	The HL7 Version 3.0 Messaging Standard is an application protocol for electronic data exchange in healthcare. Version 3.0 is based on a Reference Information Model (RIM); which is used to instantiate various message formats. Value sets/code tables are contained in the standard. For more information visit www.hl7.org
Integrating the Healthcare Enterprise (IHE) Quality, Research and Public Health (QRPH) Technical Framework Supplement 2008 – 2009, Drug Safety Content (DSC) Profile, Public Comment, Version 10	Describes the content and format to be used within the Pre-population Data transaction described within the RFD Integration Profile. The purpose of this profile is to support a standard set of data in CCD format which the Form Filler provides for use in reporting adverse events as it relates to Drug Safety. In addition this profile will reference the ability to convert this output into the ICH E2B (R3) standard. For more information visit www.ihe.net



2.3.3 INFORMATIVE REFERENCE STANDARDS

Table 2-6 Informative Reference Standards

Standard	Description
No applicable informative reference standards	



3.0 APPENDIX

The following sections include relevant materials referenced throughout this document.

No additional information at this time.



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 construct address the following comments received during the Public Comment and Inspection Testing period (September 29 – October 24, 2008).

The associated comment numbers for these updates are as follows:

5455

4.1.1 SECTION 1.1 OVERVIEW

Clarified that this Component specifies data that is available in a CDA document that may be used to pre-populating a public health case report. For those attributes that are universal for case reporting but not available in a CDA document the reader should refer to the HITSP Interoperability Specification for any further information or specific constraints.

4.1.2 SECTION 2.2.1 DATA MAPPING

- Removed those data elements that were not supported in a CDA document
- Removed the destination column
- Provided clarification of the values used in the Optionality column, specifically R, R2, C, and O.

Minor editorial changes were made to this document.

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

Minor editorial changes were made to this document. Boilerplate text was removed 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.

