Conformance Reporting User Guide

Version 8

July 15, 2026

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1 Introduction

Conformance standards, which involve adherence to defined specifications, standards, and guidelines, aim to consistently enhance the data flowing through the Michigan Health Information Network Shared Services (MiHIN). This ensures that the information received by practitioners is both complete and actionable. Conformance thresholds apply to all inpatient, observation, and emergency department (ED) visits.

Hospitals must uphold data quality standards for all Admission, Discharge, and Transfer (ADT) messages, Continuity of Care Document (C-CDA) transmissions and Statewide Lab result messages. ADT messages must consistently meet the associated conformance threshold in three key areas:

- Complete routing
- Complete mapping
- Adherence to coding standards

C-CDA data conformance is achieved when all medication reconciliation fields are fully routed.

Statewide Lab Result data conformance is achieved when all relevant lab result fields are fully routed

1.1 Purpose of the Conformance Module

The primary aim of the Conformance Module is to provide automated conformance reporting for ADTs, CCDs, and ORUs to customers at any time. It serves two main functions:

1. **Display the Conformance Report** for the user's organization in an easily accessible format.
    - **Note:** These reports do not contain Protected Health Information (PHI) and instead provide aggregated evaluations of various fields or segments within messages.
2. **Enable Access to Live Production Messages** of the specified message type (ADTs, CCDs. and ORUs). This feature illustrates the reasons behind the organization’s conformance scores—whether compliant or not. These messages are live and contain PHI but are limited to those sent by and originating from the user's logged-in organization. These instances are referred to as "fallout examples."

To fully utilize the capabilities of the conformance reporting, users must first have a MIGateway account provisioned and the Conformance Module activated. Once set

up, users can engage with the module's features, including viewing general reports and searching for, viewing, and downloading specific message examples.

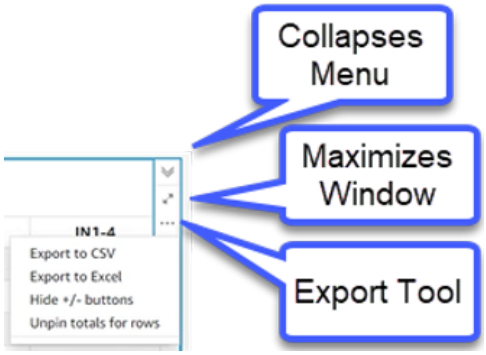
1.2 Navigating the Conformance Reporting Module

This guide aims to help you and your organization proficiently maneuver through the Conformance Reporting Module of the MIGateway platform. Take advantage of this resource to fully harness the capabilities that the Conformance Reporting module provides.

Note: The reports featured in this guide, along with their data within the Conformance Reporting Module, will differ according to the specific Conformance Reporting permissions assigned to your user.

1.3 Document Conventions

When the user clicks within the reporting window, a menu may appear on the far right, providing the option to export the data.



***Note**: Necessary information.*

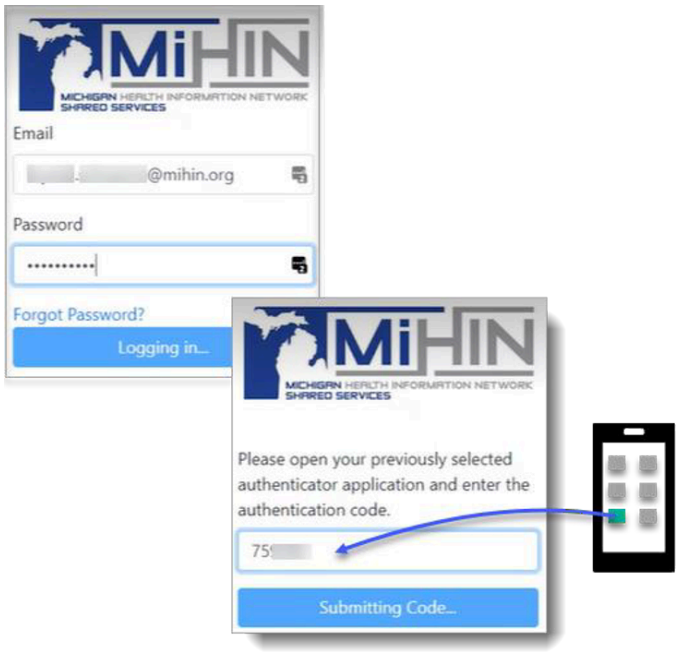
***Tip**: Helpful information.*

***Caution**! Must follow information.*

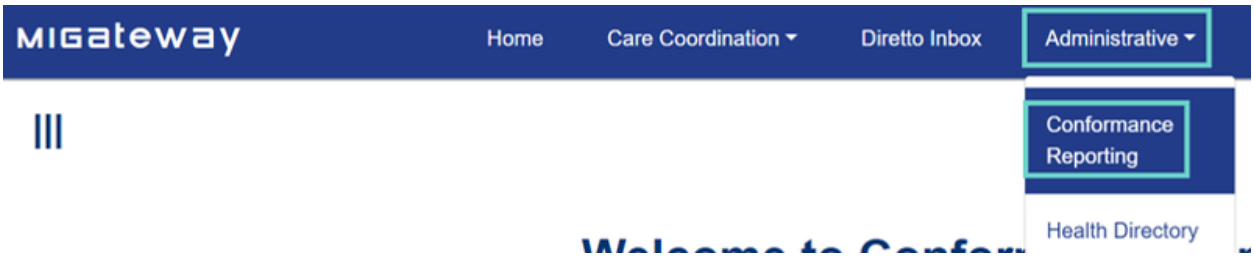
2 Viewing Conformance Reports in MIGateway

2.1 Logging in

1. Log into MIGateway, and enter your authentication code.



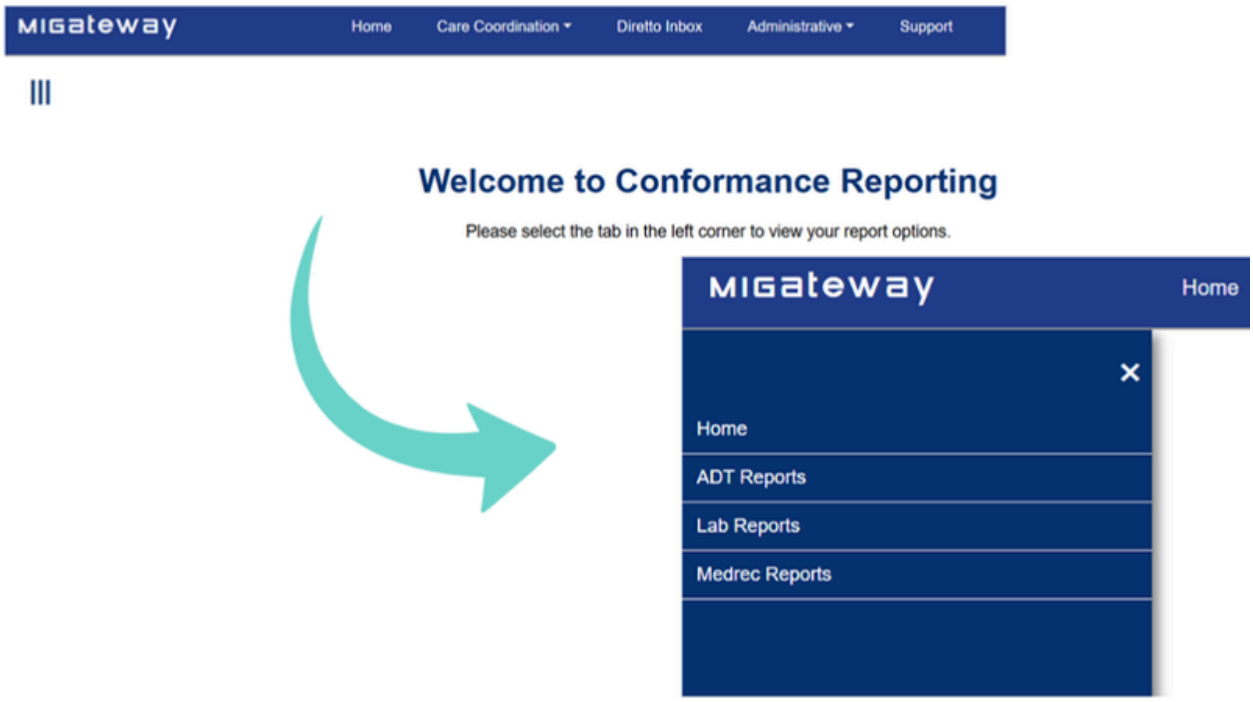
2. Choose the **Administrative** drop down menu, and then choose **Conformance Reporting**.



3. The **Welcome to Conformance Reporting** window will appear.

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

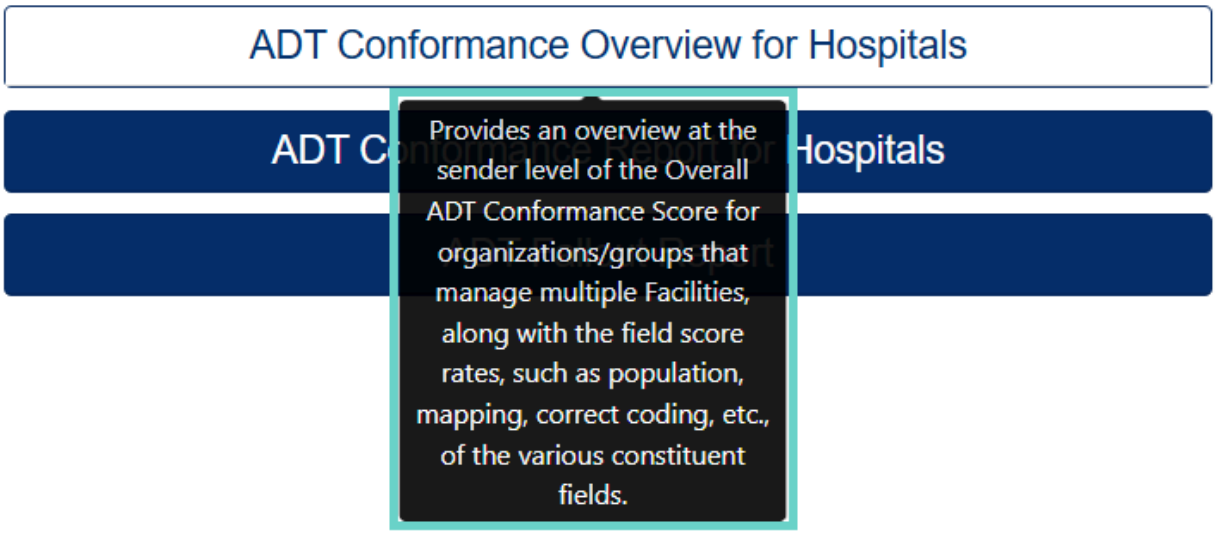
4. Click on the **vertical bar** in the upper left-hand corner, and a side bar will appear. In the side bar, the end user will be presented with the Conformance Reports that their account is provisioned to have access to. The side bar, however, will display the following options:
    - **Home**
        - Selecting this option will always redirect the user back to the main Conformance Reporting screen.
    - **ADT Reports**
        - These reports pertain specifically to ADT Notifications. Consequently, users will have access to various conformance report options. If the user's organization is not sending ADT Notifications to MiHIN as part of the ADT Notification Data Exchange Solution, this option will be unavailable to them.
    - **Lab Reports**
        - These reports focus on Statewide Lab messages; therefore, users will see the Statewide Lab Conformance Report options. If the user's organization is not sending lab data as part of the Statewide Labs Data Exchange Solution, this option will not be available to them.
    - **Medrec Reports**
        - These reports relate to Discharge Medication Reconciliation CCDs; thus, users may have access to up to two report options. If the user's organization is not sending CCDs to MiHIN as part of the Discharge Medication Reconciliation Data Exchange Solution, this option will be inaccessible to them.



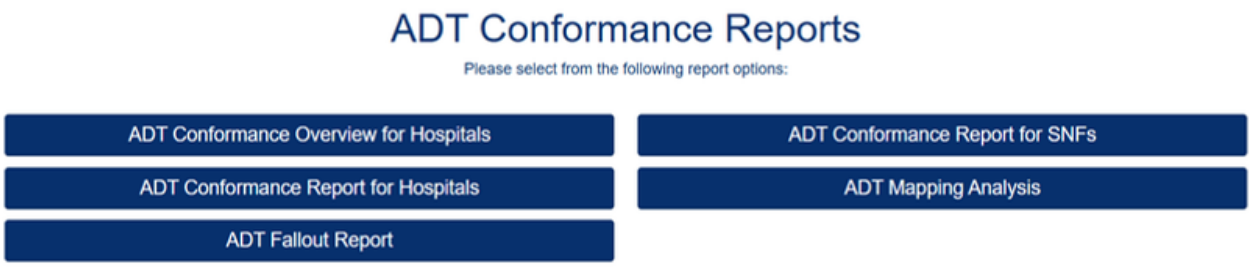
2.2 Accessing ADT Reports

When a user chooses "ADT Reports," multiple options may appear on the screen. It's crucial to understand that not all users will see the same report options, particularly depending on their access to PHI.

To gain a clearer insight into the report options available, simply hover your cursor over the blue rectangle. A description window will pop up, offering additional information about the report's purpose.



The reports listed below are currently accessible:



- **ADT Conformance Overview for Hospitals**
  - Provides an in-depth examination of the sender level concerning the overall ADT conformance score for organizations or groups managing multiple facilities. This overview also includes field score rates that address various elements such as population, mapping, correct coding, and other pertinent constituent fields.
- **ADT Conformance Report for Hospitals**
  - Delivers a thorough summary of the overall ADT conformance score at the sender level for each individual hospital. It encompasses field score rates, focusing on areas like population, mapping, correct coding, and additional relevant fields.

- **ADT Fallout Report**
  - Applies filters to pinpoint messages from the last 30 days that meet up to four specific ADT conformance criteria.
- **ADT Conformance Report for SNFs**
  - Provides a detailed overview at the sender level, highlighting the overall ADT conformance score for skilled nursing facilities (SNFs) and any organization or facility that oversees a group of skilled nursing facilities. This report also includes field score rates for aspects like population, mapping, correct coding, and more, across various constituent fields.
- **ADT Mapping Analysis Report**
  - Utilizes filters to identify messages from the past 30 days that comply with up to four unique ADT conformance criteria. Please be aware that if the end user does not have access to PHI, this option will not be available to them.

2.3 Accessing Lab Reports

When a user chooses "Lab Reports," the Statewide Lab Conformance Report will appear on the screen. Just like with ADT Reports, users can hover their cursor over the report to gain a clearer understanding of its purpose.

The report listed below are currently accessible:

- **Statewide Lab Conformance Report**
  - This report details the overall compliance rate of ORU messages transmitted to MiHIN.

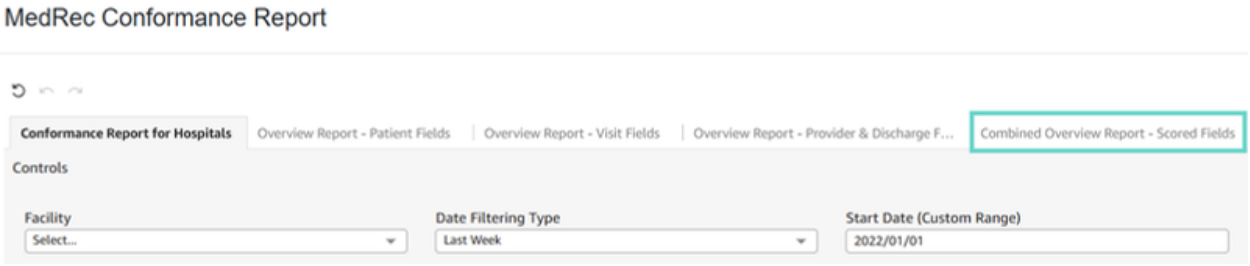
2.4 Accessing MedRec Reports

When a user chooses "MedRec Reports," multiple options may appear on the screen. It's crucial to understand that not all users will see the same report options, particularly depending on their access to PHI. Just like with ADT Reports, users can hover their cursor over each report to gain a clearer understanding of its purpose.

The reports listed below are currently accessible:

- **MedRec Conformance Report**
  - This report details the overall compliance of CCCD messages transmitted to MiHIN.
- **MedRec Fallout Report**
  - This report emphasizes CCCD messages that did not meet conformance standards.

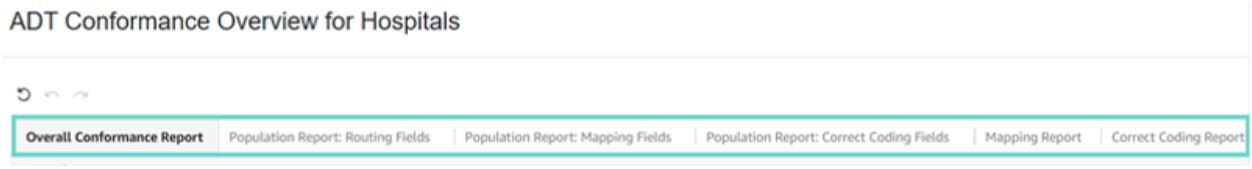
    Note: The **MedRec Conformance Report** presented below now features a new **Combined Overview Report – Scored Fields** tab. This report consolidates data from the three other Overview Report tabs and presents the same information without the color coding.



3 ADT Conformance

3.1 ADT Conformance Overview for Hospitals

This dashboard is designed mainly for health systems and hospitals that oversee multiple facilities. Once the user selects the report option, they will see a variety of reports available within the dashboard.

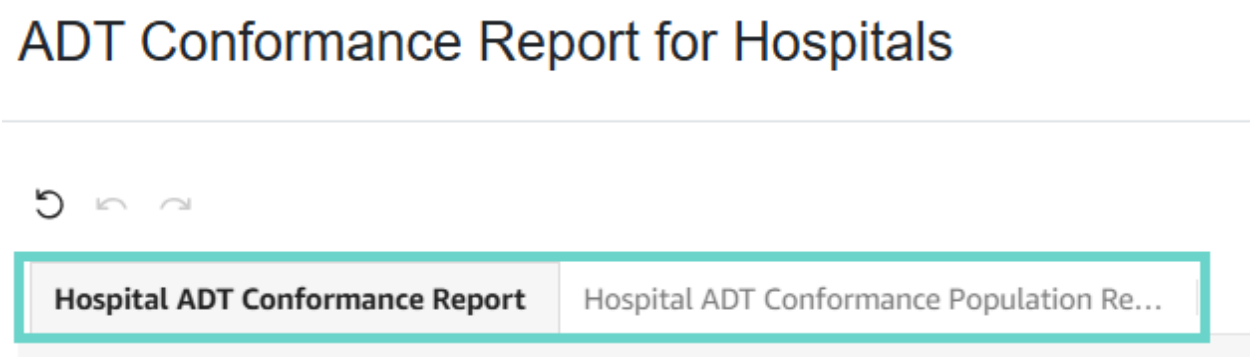


The list below offers additional insights into the various report options available:

- **Overall Conformance Report**
  - This report outlines the general conformance rates across hospitals and health systems.
- **Population Report**
  - Routing Fields
    - This section details each routing ADT conformance field, indicating the frequency with which that field was populated in the ADT messages sent during the specified period.
  - Mapping Fields
    - Here, each mapped ADT conformance field is analyzed, showing the frequency of populating that field in the messages transmitted.
  - Correct Coding Fields
    - This part covers each mapped/correct coding ADT conformance field, reporting the frequency at which that field was filled in the sent ADT messages.
- **Mapping Report**
  - This report assesses each mapped ADT conformance field, detailing the percentage of values that were accurately mapped based on the provided values in the message and the mapping table.
- **Correct Coding Report**
  - This section evaluates each correct coding ADT conformance field, indicating the percentage of values that contained properly coded content for the specified period.

3.2 ADT Conformance Report for Hospitals

This dashboard is primarily used for individual hospitals. Once the user selects the report option, they will see two reports available within the dashboard.



- **Hospital ADT Conformance Report**
  - This report offers a comprehensive summary at the sender level, showcasing the Overall ADT Conformance Score for the organization. It includes field score rates related to aspects like population, mapping, correct coding, and other key fields.
- **Hospital ADT Conformance Population Report for Hospitals**
  - This report delivers an in-depth analysis of the population rates for various fields across different ADT trigger (event) types (e.g., A01, A03, A08, etc.).

3.2.1 Hospital ADT Conformance Report

Section Definitions

The report is divided into several sections. Below, you will find the definitions for each section. Refer to Appendix B for field definitions.

- **Overall ADT Conformance Score**
  - Reflects the overall quality of ADT data.
- **Complete Routing Data by Field**
  - Shows population rates for ADT fields pertinent to routing. Specifically, this section indicates which fields (those assessed for conformance) in the displayed report are included in any ADT notifications sent to MiHIN. If a field appears blank (with no percentage or color coding), it signifies that the field is not part of the ADT notifications being dispatched.

- **Complete Mapping Data by Field**
  - Assesses the rates at which the populated values of each message segment align with the ADT service specifications. In evaluating each field for overall conformance, both the field's population rate and the mapping rate of its populated contents to the ADT service standard are taken into account. If no ADTs containing a specific mapped segment are sent, the mapping for that segment is deemed failed. In simpler terms, this section of the report scores whether the values sent in each report segment are mapped according to the organization's ADT Normalization Mapping Table. Any score below 100% indicates that some values are being transmitted, but they are not reflected in the latest ADT Normalization Mapping Table.
- **Adherence to Coding Standards by Field (Population Coding Rates/Population Rates)**
  - Evaluates the rates at which the populated values of each message segment are properly formatted for that segment (e.g., ICD-10 diagnosis codes are being transmitted). In assessing overall conformance for each field, both the population rate and the rate of properly formatted values for the segment are considered. Should no ADTs including a specific mapped segment be sent, adherence for that segment is classified as failed.

3.3 ADT Fallout Report

This report uses pre-determined filters to find messages within the last 30 days that meet up to four separate ADT conformance criteria.

3.3.1 Generating an ADT Fallout Report

Users can utilize the following controls to create an ADT Fallout Report. This report will help in understanding which ADT notifications were considered conformant, non-conformant and/or non-populated in a designated time period.

- **Number of Messages**
  - By using the drop-down menu, the user can select the total number of messages to include in the fallout report.
- **Facility/Group**
  - Use the drop-down menu to choose the facility or group name.
- **Search Period Start Date**
  - Accept the default, or choose the start date from the calendar.

        - 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, the user must select the date of interest as the start date, and the next day as the end date.
- **Search Period End Date**
    - Accept the default, or choose the start date from the calendar.
- **Trigger Type(s)**
    - Choose the types of trigger events to include in the report. To select multiple options, simply choose more than one.
- **Field of Interest**
    - Select the segment of interest to include in the report. Please be aware that there is an option to add a secondary choice in a separate field.
- **Messages to Find for Field**
    - Choose the option of interest
        - Find Conformant Messages
            - ADT notifications that met conformance requirements.
        - Find Non-Mapped/Coded Messages
            - ADT notifications that contained values that were not included on the ADT normalization mapping table.
        - Find Non-Populated Messages
            - ADT notifications that lacked any values or information in the selected field(s) of interest.
- **Field of Interest (Secondary)**
    - If relevant, choose the secondary field to be included in the report. If the user prefers not to include two fields of interest, they can leave the drop-down option set to “N/A.”
- **Messages to Find for Field (Secondary)**
    - If relevant, choose the secondary field to be included in the report. If the user prefers not to include two message types, they can leave the drop-down option set to “N/A.”

3.3.2 Downloading an ADT Fallout Report

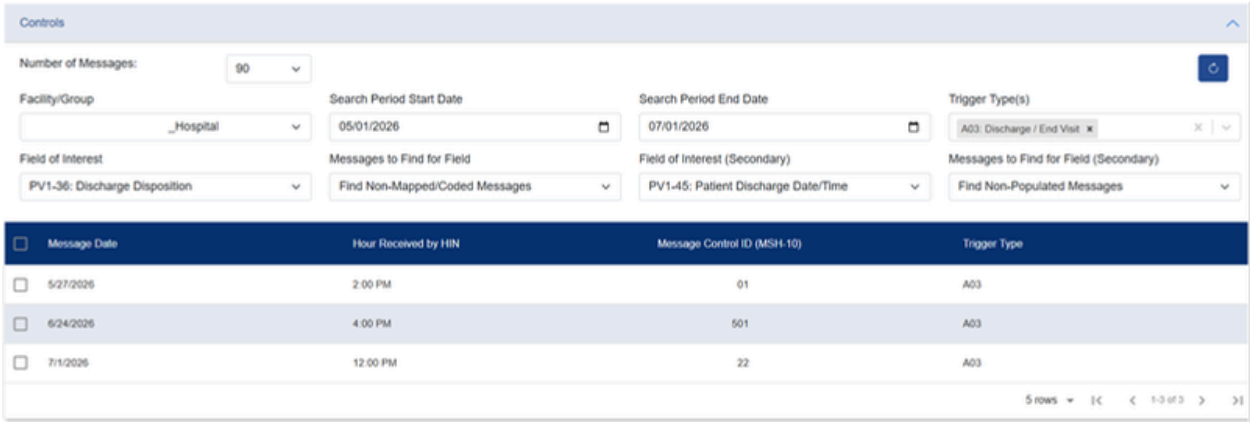
Once users input their criteria into the available filters, a report will be generated in the lower half of the screen. If no message data is displayed, it indicates that there are no messages matching the selected filters.

When a report does display, the user will see a report based on the following:

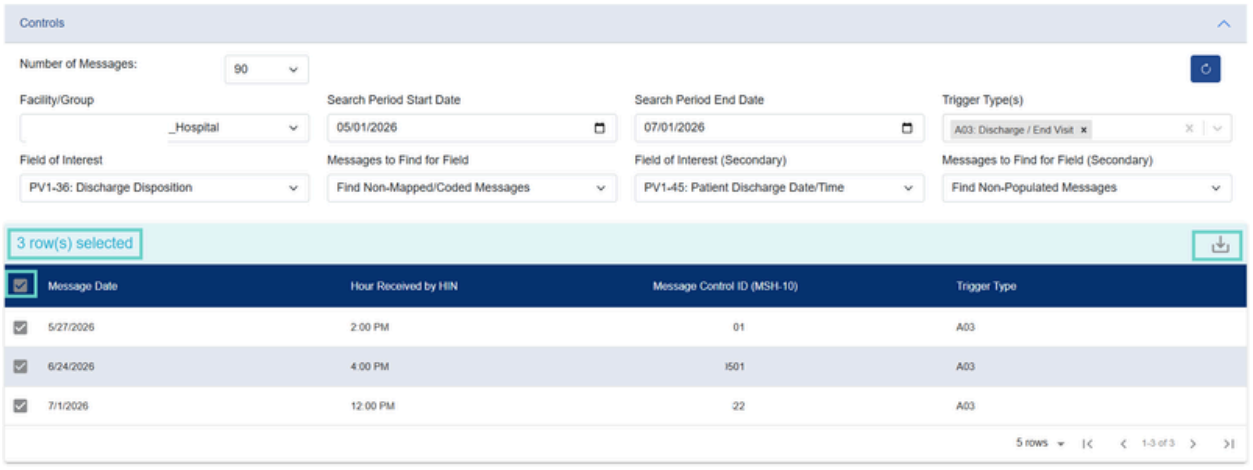
- Message Date
    - The date the message was sent to MiHIN.
- Hour Received by HIN

    - The hour MiHIN received the ADT notification.
- Message Control ID (MSH-10)
    - The message control ID in the associated ADT notification.
- Trigger (Event) Type
    - The ADT notification trigger (event) type chosen through the “Trigger Type(s)” filter.

An example of a report is shown below:



1. Under **“Message Date,”** choose one or more messages by checking the corresponding box.
2. To select all messages, simply click the box to the left of **“Message Date.”**
3. Click the download icon to download your selected message(s) or all messages.



Once the download is complete, a zip file containing the ADT notifications will be saved in your downloads folder.

3.4 ADT Conformance Report for SNFs

This dashboard is designed for all users affiliated with a Skilled Nursing Facility (SNF), as well as for any organization or facility that manages a group of SNFs. Once the user selects the report option, they will see a variety of reports available within the dashboard.

- **Overall Conformance Report**
  - Provides insights into overall conformance rates across various groups and facilities.
- **Population Report: Routing Fields**
  - Details the frequency of populated Routing ADT Conformance fields and sending facilities in ADT messages during the specified period.
- **Population Report**
  - **Mapping Fields**
    - Highlights the frequency of populated Mapped ADT Conformance fields and sending facilities in ADT messages sent.
  - **Correct Coding Fields**
    - Illustrates the frequency of populated Mapped/Correct Coding ADT Conformance fields and sending facilities in the ADT messages sent.
- **Mapping Report**
  - Analyzes the percentage of correctly mapped values in Mapped ADT Conformance fields, based on the supplied values in the message and mapping table.
- **Correct Coding Report**
  - Examines the percentage of values in Correct Coding ADT Conformance fields that accurately reflect properly coded contents during this period.

3.5 ADT Mapping Analysis

This report utilizes filters to identify messages and compiles all values transmitted within a mapped segment over a specified timeframe. It also specifies whether each value was mapped, meaning it was included in the most recent ADT Normalization Mapping Table.

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

3.5.1 Generating an ADT Mapping Analysis Report

Users can utilize the following controls to create an ADT Mapping Analysis Report. This report will help in understanding the frequency of each value transmitted and whether those values are conformant or non-conformant. This process simplifies the addition of all non-conformant values to the organization's ADT normalization mapping table.

If the participating organization requires access to the existing mapping table or wishes to upload a more recent version, please reach out to MiHIN's Help Desk (https://mihin.org/requesthelp/).

See below for a description of each available filter:

- **Facility**
  - Each user's access may differ (meaning some users might have access to more or fewer sites than their peers), but the drop-down menu can be used to select the facility name(s) to be included in the mapping analysis.
- **Field of Interest**
  - By clicking the drop-down menu, users can choose one or more items from the options list (by checking the corresponding boxes) to incorporate into the mapping analysis. Any unchecked boxes will not be represented in the analysis.
- **In Conformance?**
  - Users can choose whether to include or exclude conformant and non-conformant values in the analysis.
    - Select All: Incorporates both conformant and non-conformant values.
    - Conformant: Includes only conformant values, which are those found in the most recent ADT normalization mapping table.
    - Non-Conformant: Includes only non-conformant values, which are not listed in the most recent ADT normalization mapping table.
- **Start Date**
  - A calendar window will pop up, or users can input the start date in the YYYY/MM/DD format to specify the beginning of the analysis.
    - 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.
- **End Date**
  - A calendar window will appear, or users can enter the end date in the YYYY/MM/DD format to determine the conclusion of the analysis.

After selecting the available filter options, the user will be displayed with the following information within the analysis:

- **Group Name**
  - Displays as a provider health system name. There may be cases where this field will be populated with "*null.*"
- **Facility**
  - Displays as the hospital name (or names) that was chosen using the "Facility" drop-down menu within the Controls panel.
- **Mapping field**
  - Displays a list of segments that were present in the ADT notifications that were sent to MiHIN.
- **Conformant?**
  - Displays whether the field is mapped (conformant) or unmapped (non-conformant).
- **Value**
  - The value will vary between a character, number, or word as defined either by what was included in the ADT normalization mapping table and was included in the ADT notification sent to MiHIN, or it indicates the value that was sent (in the specific segment) but was not included in the ADT normalization mapping table. This field should be used in conjunction with Mapping Field and Conformant?
- **Count**
  - The total number of times the un/mapped value was sent a specific segment of the ADT notification during the designated time period.

3.5.2 Downloading an ADT Mapping Analysis Report

If the user would like to download the mapping analysis report they created, they should scroll to the white space at the end of the report on the right-hand side. There, they will find a series of three icons. By clicking on the **ellipsis** (...), the user can choose to export the report either as a comma-separated values (CSV) file or to Excel.

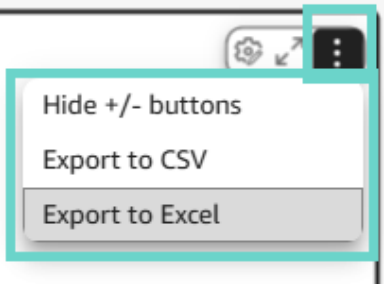
Start Date

2026/07/01

End Date

2026/07/10

Value	Count
Admitting	30
C	11
F	9



3.6 ADT Trigger (Event) Type Definitions

Below is a table of HL7 ADT message types and associated descriptions that can be referenced 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

3.7 Understanding the Population Requirements for Messages Chart

The chart below outlines the necessary ADT data and conformance thresholds for messages. By utilizing this chart, users can identify how to achieve the required conformance thresholds. On the left side, you will find the various message types, while the corresponding segments are shown on the right. The bolded lines separate the segments into three distinct sections: routing data, complete mapping, and coding standards.

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-18	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.																					

4 Lab Reports (Statewide Labs) Conformance

4.1 Statewide Lab Conformance Report

This dashboard is designed mainly for health systems and hospitals that oversee multiple facilities. Once the user selects the report option, they will see two different reports that are available within the dashboard.

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

If your organization is part of the P4P Incentive program, please consult the P4P guidelines for your organization's compliance requirements and thresholds. Below is a list that provides further insights into the two available report options:

- **ORU Conformance Report for Facilities**
  - This report offers an in-depth analysis of the population rates for various fields across the lab (ORU) messages.
- **Overview Report**
  - This report offers a comprehensive summary at the sender level, showcasing the overall ORU conformance core for the organization/health system. It includes field score rates related to aspects like population, mapping, correct coding, and other key fields.

4.1.1 Lab Conformance Report Fields

The following fields are displayed in the ORU conformance reports:

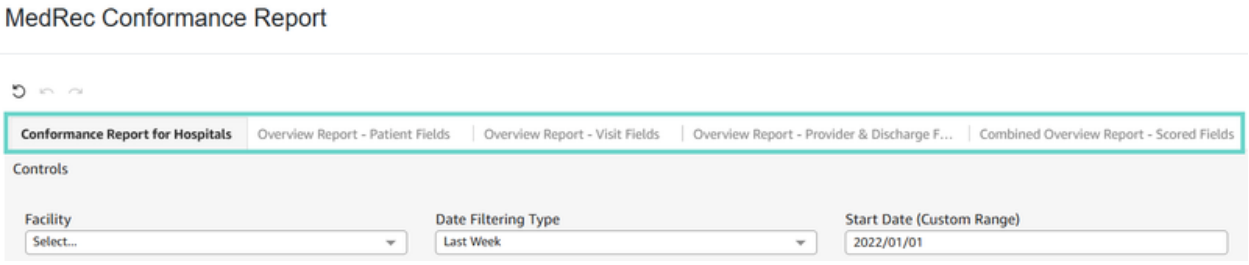
Segment	Field identifiers	Description
MSH	MSH-3.1	Sending Application Namespace ID
	MSH-4.1	Sending Facility Namespace ID
	MSH-4.2	Sending Facility Universal ID Date/Time of Message
	MSH-9.2	Trigger Event
	MSH-10	Message Control ID
PID	PID-2	Patient ID
	PID-5.1	Patient Family Name
	PID-5.2	Patient Given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

5 Exchange C-CDA Conformance

This section describes the reports available for Discharge Medication Reconciliation Conformance including field definitions and controls related to acute CCDs.

5.1 Med Rec Conformance Report

This dashboard is designed mainly for health systems and hospitals that oversee multiple facilities. Once the user selects the report option, they will see a variety of reports available within the dashboard.



The list below offers additional insights into the various report options available:

- **Overall Conformance Report**
  - This report outlines the general conformance rates across hospitals and health systems.
- **Overview Report - Patient Fields**
  - This report provides the conformance rates for patient related fields (e.g. patient first name, patient last name, etc.).
- **Overview Report - Visit Fields**
  - Provides the conformance rates for visit related fields (e.g. encounter type, visit number, chief complaint, etc.).
  - *Note: There are several fields that are included in this report, but are greyed out. This is because these fields are not currently scored for P4P, but provide the user further insight regarding the data in the fields being sent.*
- **Overview Report - Provider and Discharge Fields**
  - Provides the conformance rates for provider and discharge related fields (e.g. provider last name, provider NPI, etc.).
  - *Note: There are several fields that are included in this report, but are greyed out. This is because these fields are not currently scored for P4P, but provide the user further insight regarding the data in the fields being sent.*
- **Combined Overview Report - Scored Fields**
  - Provides the conformance rates for all sections.

5.2 Med Rec Fallout Report

This report will help in understanding which CCDs were considered conformant, non-conformant in a designated time period.

5.2.1 Generating a Med Rec Fallout Report

Users can utilize the following controls to create a Med Rec Fallout Report.

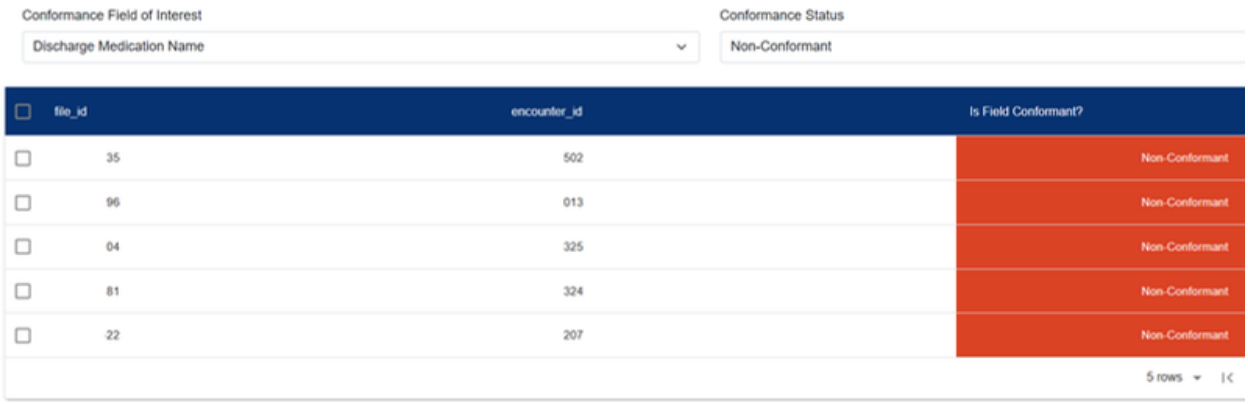
- **Number of Messages**
  - By using the drop-down menu, the user can select the total number of messages to include in the fallout report.
- **Facility/Group**
  - Use the drop-down menu to choose the facility or group name.
- **Date Filtering Type**
  - Should the user prefer not to utilize a custom date range, they have the option to choose from the pre-defined selections available in the drop-down menu.
- **Start Date (Custom Range)**
  - Accept the default option or select a start date from the calendar. If the Date Filtering Type does not include a specific option, the user should utilize custom ranges.
    - *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, the user must select the date of interest as the start date, and the next day as the end date.*
- **End Date (Custom Range)**
  - Accept the default option or select a start date from the calendar. If the Date Filtering Type does not include a specific option, the user should utilize custom ranges.
- **Conformance Field of Interest**
  - Select the segment of interest to include in the report.
- **Conformance Status**
  - All
    - Includes all CCDs that met conformance requirements, and those that did not meet conformance requirements.
  - Conformant
    - Includes only CCDs that met conformance requirements.
  - Non-Conformant
    - Includes only non-conformant CCDs.

5.2.2 Downloading a Med Rec Fallout Report

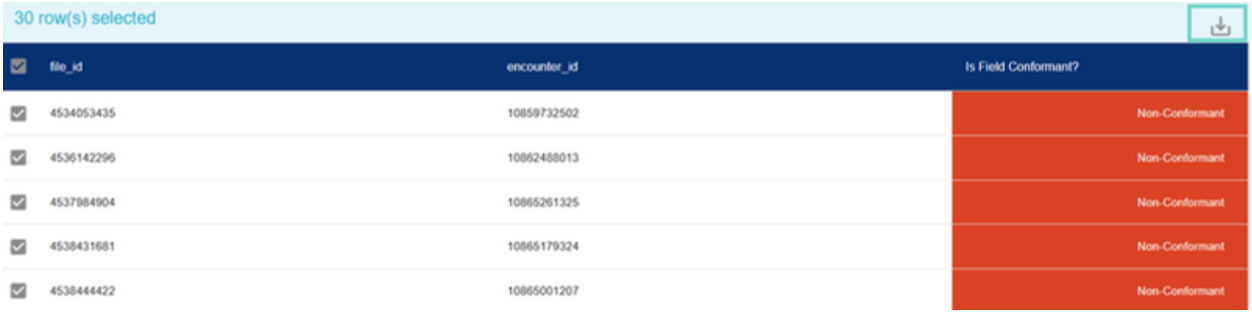
Once users input their criteria into the available filters, a report will be generated in the lower half of the screen. If no message data is displayed, it indicates that there are no messages matching the selected filters.

When a report does display, the user will see a report based on the chosen options via the available filters.

An example of a report is shown below:



1. Under **"file_id,"** choose one or more messages by checking the corresponding box.
2. To select all messages, simply click the box to the left of **"file_id"**
3. Click the download icon to download your selected message(s) or all messages.



1.

Once the download is complete, a zip file containing the CCDs will be saved in your downloads folder.

5.3 Med Rec Requirements

5.3.1 Required XPaths

Below is a compilation of the XPaths utilized in the XML document. The **Description** column outlines the data elements found within the Med Rec Conformance report, while the **XPaths** column indicates the paths used to verify the existence of each 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/nam e/given or componentOf/encompassingEncounter/encounterParticipant/assignedEntity/assignedPerson/name/given
	Attending Provider Last Name	documentationOf/serviceEvent/performer/assignedEntity/assignedPerson/nam e/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/sect

		ion/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/sect
		ion/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/La boratory 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"
		if component/structuredBody/component/sect

	Visit Diagnosis Description	ion/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"
		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/templat eId/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/sect

	Discharge Medication Name	ion/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/templat eId/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/templat eId/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
		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"
	Discharge Medication Code	then component/structuredBody/component/section/templateId/entry/act/templat eId/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/templat eId/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"
		if component/structuredBody/component/section/templateId/root ==
	Discharge	"2.16.840.1.113883.10.20.22.2.11" or

	Medication Begin Date	"2.16.840.1.113883.10.20.22.2.11.1" then component/structuredBody/component/section/templateId/entry/act/templat eId/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/templat eId/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/templat eId/root ="2.16.840.1.113883.10.20.22.4.35"/entryRelationship/substanceAdministratio

		n/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/templat eId/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/templat eId/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
		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

		then component/structuredBody/component/section/templateId/entry/act/templat eId/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"
	Discharge Medication Instructions	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/templat eId/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"

5.3.2 XPath Exclusions

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 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.*

5.3.3 Template OID Descriptions

This list outlines the template Object Identifiers (OIDs) utilized 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.
		The Hospital Discharge Medications section defines the medications that the patient is intended to take (or stop)

Hospital

2.16.840.1.113883.10.20.22.2.11	Hospital Discharge Medications List	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.
	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
2.16.840.1.113883.10.20.22.4.16		substanceAdministration/effectiveTime

2.4.16		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.
		This section lists and describes all

2.16.840.1.113883.10.20.22.2.5.1	Problems	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.
	Advanced	Advanced Directives Observations assert findings, for example,

"resuscitation status is Full Code"

2.16.840.1.113883.10.20.22.4.48	Directive Observation	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.
		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

	Advanced Directives	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		
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/effectiveTim e.

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.
		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

		chemistry, serology, virology, toxicology, microbiology, plain x-ray, ultrasound, CT, MRI, angiography, echocardiography, nuclear medicine, pathology, and procedure
2.16.840.1.113883.10.20.22.2.3.1	Results	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.
		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.
2.16.840.1.113883.10.20.22.2.17	Social History	
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.
		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,

2.16.840.1.113883.10.20.2	Encounters	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
2.2.22		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.
2.16.840.1.113883.10.20.2 2.4.49	Encounter Activities	This clinical statement describes the interactions between the patient and clinicians. Interactions include in-person encounters, telephone conversations, and email exchanges.
2.16.840.1.113883.10.20.2 2.2.16	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.

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 fields. 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 won't have a diagnosis until after discharge. Could you instead use the diagnosis in the A08 message?
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.
Why do I have a blank field in the Conformance Module dashboard?
No messages met the criteria necessary for measuring that field.
What happens if a patient leaves without being seen? In such cases, they won't have any diagnosis to document.
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 updating the dates, yet my scores remain unchanged. What could be the reason for this?
If you are utilizing a custom period, make sure to select 'custom period' as the value in the 'period of interest' field.
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

Field/Segment	Definition
DG1-3.1	Diagnosis Code ID
DG1-3.2	Diagnosis Code Text
DG1-6	Diagnosis Type
IN1-3	Insurance Company ID
IN1-4	Insurnace Company Name
PID-5.1	Patient Last Name
PID-5.2	Patient First Name
PID-7	Patient DOB
PID-8	Patient Sex
PID-9	Patient Race
PID-11.5	Patient Zip
PID-19	Patient SSN
PID-22	Ethnic Group
PID-29	Patient Death Date/Time

PID-30	Patient Death Indicator
PV1-2	Patient Class
PV1-4	Admission Type
PV1-7	Attending Provider ID
PV1-10	Hospital Service
PV1-14	Admit Source
PV1-17	Admitting Provider ID
PV1-19	Visit Number
PV1-36	Discharge Disposition
PV1-37	Discharged to Location
PV1-44	Admit Date/Time
PV1-45	Discharge Date/Time