HIT Standards Commitee - Joint Working Groups on Quality and Operations
Meaningful Use Measure Grid - Data Elements Mapped to HITEP Datatypes

Standard Categories	Quality Data Types	HITEP Definition	Data Elements	Standard (Applies to Quality Data Elements in Column B unless otherwise noted)
communication	communication to patient	Providing any communication to the patient. E.g., results, findings, plans for care, medical advice, instructions, educational resources, appointments, results, etc.	smoking cessation counseling / advice	
condition / diagnosis / problem	diagnosis active	A problem, diagnosis or condition that is currently monitored, tracked or is a factor that must be considered as part of the treatment plan in progress.	active diagnosis congestive heart failure	SNOMED CT or ICD-9 for 2011; SNOMED CT or ICD-10* for 2013
			active diagnosis left ventricular systolic dysfunction	
			active diagnosis of anuric renal failure	
			active pregnancy	
			moderate to severe aortic stenosis diagnosis	
			active diagnosis persistent asthma	
			active diagnosis ischemic stroke	
			active diagnosis atrial fibrillation	
			active diagnosis coronary artery disease	
			active Hepatitis b	
			patient self-reported diagnosis	
			active diagnosis ischemic vascular disease	
			burn diagnosis	
			urgent / emergent medical situation	
			terminal illness	
			hypertension diagnosis	
			elevated blood pressure diagnosis	
			borderline hypertension diagnosis	
			intermittent hypertension diagnosis	
			active diabetes diagnosis	
			active gestational diabetes diagnosis	
			active polycystic ovarian disease diagnosis	
			steroid induced diabetes active diagnosis	
			hospital discharge diagnosis AMI	
			smoking history	
			active ischemic vascular disease diagnosis	
	diagnosis past history	Problems, conditions and diagnoses that have occurred in the past for the patient under treatment.	past history angioedema	SNOMED CT or ICD-9 for 2011; SNOMED CT or ICD-10* for 2013
			past history myocardial infarction	
			varicella history	
			history of colorectal cancer diagnosis	
			history of hypertension	
device	device applied	Indication that equipment designed to treat, monitor or diagnose a patient's status is in use. An example in a venous thromboembolism measure is that an anti-thrombotic device has been placed on the patient's legs to prevent thromboembolism.	Antithrombotic device applied	
	device intolerance	Device intolerance is a reaction in specific patients representing a low threshold to the normal actions of a device. Side effects experienced do not represent adverse events or allergies. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.	Antithrombotic device intolerance	
	device declined	Equipment designed to treat, monitor or diagnose a patient's status has been declined by the patient.	Antithrombotic device refused	No recommendation
diagnostic study	diagnostic study performed	Evidence that a diagnostic study on a patient has been completed. Diagnostic studies are those that are not performed in the clinical laboratory. Such studies include but are not limited to imaging studies, cardiology studies (electrocardiogram, treadmill stress testing), pulmonary function testing, vascular laboratory testing, and others.	mammography performed	SNOMED CT, or CPT4 and ICD-9, for 2011; SNOMED CT, or CPT4 and ICD-10*, for 2013
			colonoscopy performed (Note: CAT Scan imaged colonoscopy will be added to the code set for colonoscopy)	
			double contrast barium enema performed	

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			flexible sigmoidoscopy performed	
	diagnostic study result	The result, described in concepts or numerical values of a diagnostic on a patient. Diagnostic studies are those that are not performed in the clinical laboratory. Such studies include but are not limited to imaging studies, cardiology studies (electrocardiogram, treadmill stress testing), pulmonary function testing, vascular laboratory testing, and others.	left ventricular systolic ejection fraction	LOINC or SNOMED CT observable
encounter	Encounter	A patient encounter represents interaction between a healthcare provider and a patient as with a face-to-face or otherwise billable visit for any form of diagnostic treatment and/or therapeutic event. The location within a healthcare setting at which a patient is located.	outpatient visit encounter	HL7 v.2.5.1, or CPT 4 and ICD-9, for 2011; HL7 v.2.5.1, or CPT 4 and ICD-10*, for 2013
			hospital admission	HL7 v.2.5.1
			hospital discharge	
			discharge from long term care	
			admission to long term care	
			ambulatory care encounter	
individual characteristic	patient characteristics	Specific information about the patient, including demographics	age (birthdate)	Date using HL7 v2.5.1 TS datatype
			death	HL7 v.2.5.1 Table 0112
			gender	HL7 v.2.5.1 Table 0001
			insurance type	X12 v.4010A1 Health Insurance Type Data Element 1336
			primary language	HL7 v.2.5.1 Table 0296
			race	HL7 v.2.5.1 Table 0005
			ethnicity	HL7 v.2.5.1 Table 0189
			clinical trials for VTE	No recommendation
			discharge status alive	HL7 v.2.5.1 Table 0112
laboratory test	laboratory test performed	A study in the clinical laboratory (traditionally Chemistry, Hematology, Microbiology, Serology, Urinalysis, Blood Bank) has been completed. Depending on the point in the clinical workflow desired by the measure, various options are provided - offered, declined, ordered, performed and resulted.	fecal occult blood test performed	LOINC
	laboratory test result	The result of a study in the clinical laboratory (traditionally Chemistry, Hematology, Microbiology, Serology, Urinalysis, Blood Bank). Depending on the point in the clinical workflow desired by the measure, various options are provided - offered, declined, ordered, performed and resulted.	Hepatitis b immunity	LOINC
			non-laboratory documentation of LDL+D89	
			LDL to HDL ratio	
			LDL result	
			lipid profile result	
			HbA1c result	
medication	medication administered	A record by the care provider that a medication actually was administered and whether or not these facts conform to the order. Appropriate time stamps for all medication administration are generated.	anticoagulation therapy administered	NCPDP script 10.X for ambulatory administration; and/or HL7 v.2.5.1 as specified by HITSP for inpatient administration; and/or HL-7 v.2.3.1 for immunization and vaccination administration
			pneumococcal conjugate vaccine administered	
			pneumococcal vaccine history (from patient)	
			VZV administered (varicella zoster vaccine)	
			Hepatitis b vaccine administered	
			Hib administered (Hemophilus influenza b vaccine)	
			MMR administered (measles, mumps, rubella vaccine)	
			IPV administered (D135inactivated polio vaccine)	
			DtaP/Dt administered (diphtheria, tetanus, acellular pertussis / diphtheria, tetanus vaccine)	
			chemotherapy history	
			influenza vaccine history	

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			influenza vaccine administered	
			influenza vaccination documented (from patient source)	
			warfarin administered	
			VTE prophylaxis medication administered	
	medication allergy	A medication allergy is an immunologically mediated reaction that exhibits specificity and recurrence on re-exposure to the offending drug. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.	angiotensin converting enzyme inhibitor allergy	UNII and RxNorm
			influenza vaccine allergy	
			pneumococcal vaccination anaphylaxis history	
	medication dispensed	A medication prescription is filled by a pharmacy the medication has been provided to the patient or patient proxy. In the ambulatory setting, medications are primarily taken directly by patients and not directly observed. Hence, dispensed is the closest health provider documentation of medication compliance. In settings where patients attest to taking medications in electronic format (perhaps a Personal Health Record) patient attestation of 'medication taken' may be available.	short-acting beta 2 agonist inhaler dispensed	NCPDP script 10.X for ambulatory medications; and HL7 v.2.5.1 as specified by HITSP for inpatient medications; and HL-7 v.2.3.1 for vaccines
	medication intolerance	Medication intolerance is a reaction in specific patients representing a low threshold to the normal pharmacological action of a drug. Side effects experienced do not represent adverse events or allergies. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.	angiotensin converting enzyme intolerance	SNOMED CT
			influenza vaccine intolerance	
			VTE prophylaxis medication intolerance	
	medication order	A request by a physician or appropriately licensed care provider to a pharmacy to provide medication to a patient. The request is in the form of prescriptions or other medication orders with detail adequate for correct filling and administration.	angiotensin converting enzyme	NCPDP script 10.X for ambulatory medications; and HL7 v.2.5.1 as specified by HITSP for inpatient medications; and HL-7 v.2.3.1 for vaccines
			inhibitor prescription	
			beta blocker prescription	
			documentation no medications were prescribed at discharge	
			discharge medication list	
			ambulatory medication list	
			antithrombotic medication order	
			aspirin medication order	
			high risk medication for elderly prescribed	
			antihyperglycemic medication prescription	
			insulin prescription	
			hypoglycemic medication prescription	
	medication offered	A specific medication has been offered to the patient or patient proxy.	influenza vaccine offered	SNOMED CT
			pneumococcal vaccine offered	
physical finding	physical exam finding	A physical examination is the evaluation of the patient's body to determine its state of health. The techniques of inspection include palpation (feeling with the hands and/or fingers), percussion (tapping with the fingers), auscultation (listening), and smell. Measurements may include vital signs (blood pressure, pulse, respirations) as well as other clinical measures (such as expiratory flow rate, size of lesion, etc.).	heart rate < 50 (bradycardia) physical finding	SNOMED CT
			BMI (basal metabolic index)	
			Systolic blood pressure	
			Diastolic blood pressure	
preference	patient preference	Health care treatment choices influenced by but not limited to language, religious, or cultural preferences selected by the patient and family.	patient refusal	SNOMED CT
			signed out against medical advice	
			comfort measures only	
			patient reason for not receiving influenza vaccine	
			influenza vaccination refused	
			patient reason for not receiving pneumococcal vaccine	
	provider preference	Health care treatment choices by the care provider based on knowledge of the patient's clinical status and findings. Synonymous with 'medical reason' for inclusion or exclusion of a patient in a	medical reasons for avoiding ACEI, ARB	No recommendation
			medical reason for not administering influenza vaccine	

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		measure population.	medical reason for not prescribing pneumococcal vaccine	
			medical exclusion (general)	
Procedure	procedure performed	A procedure has been completed. Depending on the point in the clinical workflow desired by the measure, various options are provided - offered, declined, ordered, performed and resulted. Procedures also include patient care processes provided directly to a patient by a care provider to assist or direct a patient with activity or to apply single use or durable medical equipment. Examples include assisted ambulation, behavioral interventions (e.g., counseling provided), dressing changes, placement of antithrombotic devices, insertion or removal of intravascular access. Some of these procedures are not reimbursed.	elective carotid endarterectomy performed	SNOMED CT
			radiation therapy history	
			bone marrow transplant history	
			chemotherapy history	
			history of bilateral mastectomy procedure	
			history of mastectomy procedure	
			history of colectomy procedure	
			Neuraxial anesthesia performed (end time)	
			Neuraxial anesthesia performed (start time)	
			General anesthesia performed (start time)	
			General anesthesia performed (endtime)	
			laparoscopic procedure performed	
			PTCA procedure (percutaneous transluminal coronary angioplasty)	
			hospital admission for CABG	
	procedure result	Procedure results are the findings identified as a result of the procedure. The result of a surgical procedure documents the actual procedure performed and the findings of the procedure. These findings are usually present in the operative note (e.g., lymph node dissection with 15 lymph nodes obtained for biopsy). The procedure result is distinct from the pathology report which is a laboratory result datatype which could state 2 of 15 nodes positive for malignancy. It is also distinct from clinical outcome which could use various datatypes (e.g., patient characteristic 'alive' at 18 months post-operatively, *or* functional status datatype required pre-operatively and at 6, 12, and 18 months post-operatively).	left ventricular function diagnostic study result	SNOMED CT
risk category / assessment	risk category / assessment	Risk category assessments include tools and calculators that suggest vulnerabilities for any given patient. Distinct from functional status, risk categorization uses findings, observations, results and sometimes judgments and patient generated information for use within clinical care algorithms, clinical decision support and severity analysis.	nursing home risk category assessment	SNOMED CT
			smoking readiness to quit assessment	
substance	substance allergy	A substance allergy is an immunologically mediated reaction that exhibits specificity and recurrence on re-exposure to the offending substance. A time/date stamp is required as are notations indicating whether the item is patient reported and/or provider verified.	egg allergy	UNII
Transfer of care	transfer to	The setting to which a patient is released (e.g., home, acute care hospital, skilled nursing, rehab, etc.) from the current location.	transfer to inpatient facility	SNOMED CT
			transfer to short-term hospital	
			discharge to hospice	
			transfer to acute care hospital	