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Table of Participating Sponsors, Plans, Products and associated Identifiers

Appendix A – ITI-41 (XDS.b) Provide and Register Document Set

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1. DOCUMENT CHANGE HISTORY

<table>
<thead>
<tr>
<th>Version</th>
<th>Issue Date</th>
<th>Modified By</th>
<th>Comments/Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>February, 2016</td>
<td>Rhonda May</td>
<td>First draft of Implementation Guide for C-CDA Documents</td>
</tr>
<tr>
<td>1.1</td>
<td>February 17, 2016</td>
<td>Rhonda May</td>
<td>Clarification of data confidentiality requirements, update web link, correct typographical errors, add mapping table, add error handling section, add section for C-CDA correction.</td>
</tr>
<tr>
<td>1.2</td>
<td>February 22, 2016</td>
<td>Rhonda May</td>
<td>Updated Mapping Table</td>
</tr>
<tr>
<td>1.3</td>
<td>March 21, 2016</td>
<td>Rhonda May</td>
<td>Added information about mapping table information available on the OHP HIE website</td>
</tr>
<tr>
<td>1.4</td>
<td>April 2016</td>
<td>Rhonda May</td>
<td>Update name element sequence information</td>
</tr>
<tr>
<td>1.5</td>
<td>May 2016</td>
<td>Rhonda May</td>
<td>Add specific reference to the version of HL7 C-CDA implementation guided being used for C-CDA processing at the HIE. Update name element sequence information with reference to the implementation guide</td>
</tr>
<tr>
<td>1.6</td>
<td>August 2016</td>
<td>Rhonda May</td>
<td>Document enhancements, add/update specificity on data requirements and constraints, add supported XDS.b ITI protocols</td>
</tr>
</tbody>
</table>

2. INTRODUCTION

2.1. Overview

OneHealthPort offers Clinical Data Repository (CDR) services to organizations that are interested in collecting clinical information for a specific or “sponsored” population of patients. Current organizations sponsoring lives in the CDR include the State of Washington Health Care Authority for the Apple Health Program (Medicaid population) and Physicians of Southwest Washington for managed Medicare risk contracts. The CDR aggregates clinical data providing a patient-centric, longitudinal medical record inclusive of clinical records supplied by all contributing providers.

2.2. Scope

This implementation guide, unique to OneHealthPort, defines:

- the types of C-CDA documents trafficked over the OneHealthPort Health Information Exchange (OneHealthPort HIE) to the CDR
- any additional constraints required in the documents for OneHealthPort HIE processing
- standards in use and available with C-CDA related processing
It is intended to augment the HL7 national standard implementation guide specifically for the operationalization of C-CDA document exchange on the OneHealthPort HIE as well as the IHE protocols for document sharing. OneHealthPort is using the HL7 CDA R2 Implementation Guide: Consolidated CDA Templates for Clinical Notes (US Realm) Draft Standard for Trial Use Release 2.1 which is available on the HL7 website.

2.3. General Assumptions

- Parties to the transaction are contracted with the OneHealthPort HIE.
- The OneHealthPort HIE is not validating the structure of the C-CDA document being exchanged. Rather, it is using specific required fields in the transaction headers to determine how the document should be appropriately routed between trading partners.
- The OneHealthPort HIE is not validating content in the C-CDA document being exchanged.
- OneHealthPort will require certain document constraints for C-CDA documents being sent to the Clinical Data Repository hosted for sponsoring organizations. The CDA-R2 national standard will be the base and constrained elements or attributes required will be identified in this implementation guide.
- HIE participating organizations will successfully “pre-validate” C-CDA documents with validation testing tools provided by OneHealthPort, prior to submission to the HIE. (See section 3.11 below)
- Confidentiality of clinical information sent in C-CDA documents is assigned by practitioners using the HL7 Basic Confidentiality Kind value set where N = Normal, R = Restricted, and V = Very Restricted.

2.4. Data Confidentiality Codes

Data confidentiality codes assigned to clinical documents drive all access control to individual patient records in the Clinical Data repository. It is the responsibility of the healthcare practitioner to code the content in the C-CDA based upon the type of content in an encounter, or the patient request for data to be treated with sensitivity. The entire C-CDA has only one confidentiality code that must be based on the most confidential element in the document. All information included in the C-CDA exchange will assume the same confidentiality classification. Further information regarding the HL7 standard discussing confidentiality code assignment can be found by an internet search using the confidentiality code system object identifier 2.16.840.1.113883.5.25. The HL7 link is as follows: http://www.hl7.org/documentcenter/public_temp_2873DC00-1C23-BA17-0C63F6C676FED8DB/standards/vocabulary/vocabulary_tables/infrastructure/vocabulary/vs_Confidentiality.html

Electronic Health Record (EHR) systems must provide the means for the practitioner to identify the correct confidentiality code for information included in the C-CDA. “Normal” (N) may be the system default for data confidentiality. Practitioners must be able to adjust the confidentiality code to match the information in the record. EHR vendors should provide training and system options for maintaining ICD-10 and other codes that automatically drive a restricted or very restricted confidentiality classification or provide the capability for the provider to assign the confidentiality classification during the charting workflow.

The State of Washington Health Care Authority has developed a reference guide for Confidentiality code assignment based on ICD-10 and CPT-4 Codes associated with the record. This guide can assist vendors and practices with examples for how to classify data.

Currently the C-CDA accommodates the HL7 Basic Confidentiality Kind. In the future the standard may add a “sensitivity” classification providing more discreet definition of particular data/information in a record. A table of the confidentiality codes and their definition is shown below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Normal</td>
<td>Privacy metadata indicating that the information is typical, non-stigmatizing health information, which presents typical risk of harm if disclosed without authorization.</td>
</tr>
<tr>
<td>Level</td>
<td>Privacy Metadata</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>R</td>
<td>Restricted</td>
<td>Privacy metadata indicating <strong>highly sensitive, potentially stigmatizing information, which presents a high risk to the information subject if disclosed without authorization.</strong> May be preempted by jurisdictional law, e.g., for public health reporting or emergency treatment. Includes information that is additionally protected such as sensitive conditions mental health, HIV, substance abuse, domestic violence, child abuse, genetic disease, and reproductive health; or sensitive demographic information such as a patient's standing as an employee or a celebrity. May be used to indicate proprietary or classified information that is not related to an individual, secret ingredient in a therapeutic substance, or the name of a manufacturer.</td>
</tr>
<tr>
<td>V</td>
<td>Very Restricted</td>
<td>Privacy metadata indicating that the <strong>information is extremely sensitive and likely stigmatizing health information that presents a very high risk if disclosed</strong> without authorization. This information must be kept in the highest confidence. Includes information about a victim of abuse, patient requested information sensitivity, and taboo subjects relating to health status that must be discussed with the patient by an attending provider before sharing with the patient. May also include information held under legal lock or attorney-client privilege.</td>
</tr>
</tbody>
</table>


2.5. Document Content
This document contains information specific to the various types of C-CDA document templates and IHE protocols supported and trafficked by the OHP HIE.

2.6. Terms and Acronyms
The OneHealthPort HIE will transmit C-CDA document types listed below. Initially, for purposes of sending clinical documents to the Clinical Data Repository, only document types identified as C-CDA or CCD documents will be accepted.

### 3.1. Continuity of Care Document (CCD)

The CCD is an XML file with a core data set of the most relevant administrative, demographic, and clinical information facts about a patient’s healthcare, covering one or more healthcare encounters.

### 3.2. Consultation Note

The Consultation Note is generated as a result of a request from a clinician for an opinion or advice from another clinician.

### 3.3. Diagnostic Imaging Report

A Diagnostic Imaging Report contains a consulting specialist’s interpretation of image data. It conveys the interpretation to the referring (ordering) physician and becomes part of the patient’s medical record.

### 3.4. Discharge Summary

The Discharge Summary is a document that is a synopsis of a patient's admission to a hospital; it provides pertinent information for the continuation of care following discharge but also includes the hospital course and details of events that may not be pertinent to continuity of patient care.

### 3.5. History and Physical (H&P)
An H&P is a medical report that documents the current and past conditions of the patient to determine a patient’s health status. The H&P is typically used upon admission to a hospital or prior to an operative procedure.

3.6. Operative Note
The Operative Note is a frequently used type of procedure note with specific requirements, created immediately following a surgical or other high-risk procedure, and records the pre- and post-surgical diagnosis, pertinent events of the procedure, as well as the condition of the patient following the procedure. The report should be sufficiently detailed to support the diagnoses, justify the treatment, document the course of the procedure, and provide continuity of care.

3.7. Procedure Note
The Procedure Note is created immediately following a non-operative procedure. It records the indications for the procedure and, when applicable, post procedure diagnosis, pertinent events of the procedure, and the patient’s tolerance for the procedure. It should be detailed enough to justify the procedure, describe the course of the procedure, and provide continuity of care.

3.8. Progress Note
A Progress Note is documentation made by a nurse, physician, social worker, physical therapist, and other health care professionals, that describes a patient’s clinical status, condition and the treatment given or planned during a hospitalization or outpatient visit, including the progress or lack of progress made by the patient between the time of the previous note and the most recent note.

3.9. Referral Note
A Referral Note communicates pertinent information from a provider who is requesting services of another provider of clinical or non-clinical services. The information in this document includes the reason for the referral and additional information that would augment decision making and care delivery.

3.10. Unstructured Document
An Unstructured Document type can
- include unstructured content, such as a graphic, directly in a text element with a mediaType attribute, or
- reference a single document file, such as a word-processing document using a text/reference element.

3.11. C-CDA Document Validation
OHP HIE participating organizations exchanging C-CDA documents are required to engage in format/structure validation testing to determine messages conform to the National Institute of Standards and Technology (NIST) CDA_R2 C-CDA standard. OneHealthPort has established a testing tool on the HIE website available to HIE contracted organizations. The validation tool can be accessed by contracted organizations from this link: https://apps.onehealthport.com/OHPHIEApps

Organizations can test their C-CDA xml files using the validation testing tool with immediate response provided as to the validity of the file structure. If the test result is invalid, errors in the construct of the file will be displayed. All errors must be cleared in order to obtain a “valid” test result. Note: The testing tool also provides warning messages that may improve the file content but are not critical structure errors.

4. C-CDA document constraints for use with the Clinical Data Repository
Metadata information in the C-CDA message is used to successfully process C-CDA documents. In order to correctly process C-CDA documents certain elements and data requirement constraints have been identified below. The constrained elements are standard HL7 C-CDA message header elements.
Entities submitting C-CDAs to the CDR have two options available for placement of OHP assigned entity OIDs for delivery to specific trading partners.

The **FIRST OPTION** is to place OID information in the recordTarget/patientRole/id section of the message header, specifically as defined below:

<table>
<thead>
<tr>
<th>C-CDA Message Header Element</th>
<th>Format and Sample</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><code>&lt;patientRole/&gt;</code></td>
<td><code>&lt;id extension=&quot;CDRSponsorPtID&quot; root=&quot;CDRSponsorOHPAssignedOID&quot;/&gt;</code></td>
<td>When using the patientRole section of the message header to identify message recipients, submitting organizations must be able to include multiple id elements in the patientRole.</td>
</tr>
<tr>
<td><code>&lt;id/&gt;</code></td>
<td><code>&lt;id extension=&quot;YourPtId&quot; root=&quot;YourOHPAssignedOID&quot;/&gt;</code></td>
<td>If you have known sponsor patient identifiers and are submitting your document to the CDR, the first id extension attribute must be the CDR Sponsor patient identifier and the id root attribute must be the CDR Sponsor OID.</td>
</tr>
</tbody>
</table>

**Valid sample formats:**

**CDR Sponsor and sponsor’s patient identifier known (HCA and ProviderOne number):**

```xml
<patientRole>
  <id extension="123456789WA" root="1.3.6.1.4.1.38630.3.1"/>
  <id extension="135792468" root="1.3.6.1.4.1.38630.2.1.1.10"/>
</patientRole>
```

**CDR Sponsor patient identifier known and multiple id elements in patientRole:**

```xml
<patientRole>
  <id extension="123456789WA" root="1.3.6.1.4.1.38630.3.1"/>
  <id extension="34111726" root="2.16.840.1.113883.3.2132"/>
  <id extension="135792468" root="1.3.6.1.4.1.38630.2.1.1.10"/>
</patientRole>
```

The **SECOND OPTION** is to place source system OID information in the recordTarget/patientRole/id section of the message header, and include receiving organization information in the informationRecipient section of the C-CDA message header specifically as defined below:

<table>
<thead>
<tr>
<th>C-CDA Message Header Element</th>
<th>Format and Sample</th>
<th>Description</th>
</tr>
</thead>
</table>
| `<informationRecipient/>`     | `<intendedRecipient/>` | For purposes of document routing to an OHP hosted instance of a clinical data repository (CDR):
  - the intendedRecipient element must contain an `<id>` element which includes the following attributes:
    - extension="patient identifier of the CDR sponsor" |
| `<intendedRecipient/>`         | `<id extension="123456789WA" root="1.3.6.1.4.1.38630.3.1"/>` | |
| `<id/>`                       | `<intendedRecipient/>` | |
| `<intendedRecipient/>`         | `<id>` | |
C-CDA Message Header Element | Format and Sample | Description
--- | --- | ---
 |  |  | • root= “OHP assigned address (OID) of the sponsor CDR”
  • If the CDR sponsor’s patient identifier is not known, organizations can use a PDQ to acquire the CDR global identifier and OID. If the sponsor patient identifier was acquired through a PDQ transaction, the id extension attribute must be the CDR global patient identifier and the id root attribute must be the CDR OID (See Appendix B).

OneHealthPort has currently enumerated three CDR recipients. The table below identifies the OneHealthPort assigned address (OID) to use for sending transactions to specific CDR sponsors.

<table>
<thead>
<tr>
<th>Entity</th>
<th>Assigned address (OID) for CDR or CDR Sponsor</th>
<th>Patient Identifier information</th>
</tr>
</thead>
<tbody>
<tr>
<td>OneHealthPort Clinical Data Repository (CDR)</td>
<td>1.3.6.1.4.1.38630.3</td>
<td>The CDR global patient identifier will be used in conjunction with the CDR OID.</td>
</tr>
<tr>
<td>Washington State Health Care Authority (HCA) - Sponsor</td>
<td>1.3.6.1.4.1.38630.3.1</td>
<td>The ProviderOne patient identifier will be used in conjunction with the HCA CDR OID. Sample ProviderOne number: 123456789WA</td>
</tr>
<tr>
<td>Physicians of Southwest Washington (PSW) – Sponsor</td>
<td>1.3.6.1.4.1.38630.3.2</td>
<td>The health plan patient identification will be used in conjunction with the PSW CDR OID</td>
</tr>
</tbody>
</table>

(As additional CDR sponsors are added the table will be updated with the new assigned address (OID).)

5. Additional Submission Protocols supported at the OneHealthPort HIE

• ITI-41 Provide and Register Document Set (See Appendix A)
• ITI-47 PDQv3 Patient Demographic Query – Query (PRPA_IN201305UV02) and Response (PRPA_IN201306UV02) for patient identifiers from the CDR (See Appendix B)
• ITI-18 Registry Stored Query for documents stored in the CDR (coming soon)
• ITI-38 Cross Gateway Query for patient specific document identifiers stored in the CDR [used with ITI-55 and 39] (coming soon)
• ITI-39 Cross Gateway Query for specific CDR documents [used with ITI-38 and 55] (coming soon)
• ITI-43 Retrieve Document Set (coming soon)
• ITI-55 Cross Gateway Query for patient identifiers [used with ITI-38 and 39] (coming soon)
• Direct (coming soon)

6. Correcting C-CDA Documents already pushed outbound
In certain circumstances organizations will need to append or replace C-CDA documents for new or corrected information. The HL7 C-CDA standard provides for this circumstance through relatedDocument functionality. Organizations sending appended or replacement C-CDA documents must include an additional section in the C-CDA message header. The location in the header for the relatedDocument information is after the documentationOf section, and is shown below:

<table>
<thead>
<tr>
<th>relatedDocument</th>
<th>0..*</th>
<th>MAY</th>
<th>1098-29893</th>
</tr>
</thead>
<tbody>
<tr>
<td>@typeCode</td>
<td>1..1</td>
<td>SHALL</td>
<td>1098-31889</td>
</tr>
<tr>
<td>parentDocument</td>
<td>1..1</td>
<td>SHALL</td>
<td>1098-29894</td>
</tr>
</tbody>
</table>

Source: CDAR2_IG_CCDA_CLINNOTES_R2_D1_2014NOV_V2_Templates_and_Supporting_Material

Organizations submitting replacement or appended C-CDAs must have already done a registry stored-query (ITI-18) to obtain the unique document identifier in the CDR. That identifier must be used as the parentDocument element. An example of the relatedDocument section is show below:

```xml
<relatedDocument typeCode="RPLC">
  <parentDocument>
    <id root="aefe4f6a-d6e1-46ef-8c40-790998f7bee6" />
    <code code="34133-9" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="SUMMARIZATION OF EPISODE NOTE"/>
  </parentDocument>
</relatedDocument>
```

7. High-Level Process Description - Push
The basic process flow for the C-CDA Document processing is described as follows:

- Practitioner creates C-CDA or XDS.b documents in prescribed format with the constrained elements required.
- Practitioner sends C-CDA or XDS.b document to the OHP-HIE
- The OneHealthPort HIE identifies the document type and forwards submitted information to the intended recipient
- The OneHealthPort HIE returns the recipient acknowledgment file and any error notification generated by the recipient to the Practitioner

7.1. High-Level Process Visual Aid
7.2. OneHealthPort HIE Hub Validation

Other than at the message header, the OneHealthPort HIE does not undertake any inspection, formatting validation, content validation or transformation of CCD documents. At the message header, the HIE will parse the metadata until it sees the clinical document element. It will then run through a set of rules set up for C-CDA document processing.

8. ERROR HANDLING

8.1. C-CDA documents intended for the CDR go through stages of error handling

C-CDA xml files
- The C-CDA must “pass” the map at the HIE. If there is an issue with the file the HIE will send an email error notification;
- If the C-CDA successfully passes through the HIE map, sender will receive an OHPHIE_ACK acknowledging delivery to the CDR
- If a C-CDA fails to load in the CDR database sender will receive a negative acknowledgement (NAK) returned to the connectivity tool.
- If a C-CDA successfully loads to the CDR database sender will not receive further messaging.

XDS.b xml files
- If the XDS.b file fails to load in the CDR database sender will receive a negative acknowledgement (NAK) returned to the connectivity tool.
- If an XDS.b file successfully loads to the CDR database sender will not receive further messaging.
8.2. HIE Mapping Error Sample for CDR documents

Transaction failed at HIE Maps

Sender Id : xyz4x00
Sender Name : XYZ Company
Recipient Id : ZZOH
Recipient Name : OHP NEW PROD
Notification enabled Partner Email Id : user@xyz.com
Interchange Core Id : ci1468973879381.3897692@axwc-b2b2_te
Filename : CDA-1468973681348.xml
Document Type : CCDA
Event Date : 2016-07-19
Event Time : 17:17:59

8.3. CDR load Error Sample

<ExchangeFailureEvent>
<Failure>
<TimeStamp>Thu Jan 21 11:56:00 CST 2016</TimeStamp>
<ExchangeId>ID-s-ohp-s-lidp02-onehealthport-local-43322-1450229049985-0-495</ExchangeId>
<FailureMessage></FailureMessage>
<Response>
<ns2:RegistryErrorList highestSeverity="urn:oasis:names:tc:ebxml-regrep:SeverityType:Error">
<ns2:RegistryError codeContext="No match found for 123456789WA on MPI" errorCode="XDSRegistryError" severity="urn:oasis:names:tc:ebxml-regrep:SeverityType:Error"/>
</ns2:RegistryErrorList>
</ns2:RegistryResponse>
8.4. **Hold for Deferred Response information**

9. **FOR VENDORS - Known C-CDA problem areas**

9.1. **Effective Time**

Effective Time in the message header must be properly formatted. The table below provides additional information on proper format for the effective time element in the C-CDA message header.

<table>
<thead>
<tr>
<th><code>&lt;effectiveTime/&gt;</code> value attribute</th>
<th>YYYYMMDDhhmmss.SSSS±ZZzz</th>
<th>References the time when the C-CDA document was created or the date of original document that was transformed into the C-CDA document.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid sample formats:</td>
<td></td>
<td><strong>Required:</strong></td>
</tr>
<tr>
<td><code>&lt;effectiveTime value=&quot;20160113070212.3333-0800&quot;/&gt;</code></td>
<td></td>
<td>▪ YYY: 4 digit year</td>
</tr>
<tr>
<td><code>&lt;effectiveTime value=&quot;20160113070212-0800&quot;/&gt;</code></td>
<td></td>
<td>▪ MM: 2 digit month (with leading 0)</td>
</tr>
<tr>
<td><code>&lt;effectiveTime value=&quot;20160113070212&quot;/&gt;</code></td>
<td></td>
<td>▪ DD: 2 digit day of month (with leading 0)</td>
</tr>
<tr>
<td>▪ hh: 2 digit hour (military time)</td>
<td></td>
<td>▪ hh: 2 digit hour (military time)</td>
</tr>
<tr>
<td>▪ mm: 2 digit minute (with leading 0)</td>
<td></td>
<td>▪ mm: 2 digit minute (with leading 0)</td>
</tr>
<tr>
<td>▪ ss: 2 digit seconds (with leading 0)</td>
<td></td>
<td>▪ ss: 2 digit seconds (with leading 0)</td>
</tr>
<tr>
<td>▪ ±ZZzz: time-zone expressed as offset from UTC.</td>
<td></td>
<td><strong>Optional:</strong></td>
</tr>
<tr>
<td>▪ + means ahead of UTC</td>
<td></td>
<td>▪ SSSS: up to 4 digits for fractions of seconds</td>
</tr>
<tr>
<td>▪ − means behind UTC</td>
<td></td>
<td>▪ ±ZZzz: time-zone expressed as offset from UTC.</td>
</tr>
<tr>
<td>▪ ZZ is hour offset</td>
<td></td>
<td>▪ + means ahead of UTC</td>
</tr>
<tr>
<td>▪ zz is minute offset</td>
<td></td>
<td>▪ − means behind UTC</td>
</tr>
<tr>
<td><strong>Note:</strong> If UTC offset is included, hours and minutes are required in the offset.</td>
<td></td>
<td>If the time excludes ±ZZzz, the assumption will be that the time is already stated as UTC.</td>
</tr>
</tbody>
</table>

9.2. **Code System Names**

Code system names must have the correct corresponding OID identified. For example, medication items must have a `code` element with the correct drug code, codeSystem OID, codeSystemName and displayName attributes as appropriate.

```xml
<code code="49884-0836-66" codeSystem="2.16.840.1.113883.6.68" codeSystemName="MediSpan" displayName="Questran"/>
```

9.3. **Order of elements is important.**

For example:

- C-CDAs where postal code appears after country would fail to submit because the data elements appear out of the expected order.
  - Correct format
9.4. Lab Results
Lab Results need to be LOINC coded and included in C-CDA files.

9.5. Appropriate Language Codes
Appropriate language codes must be used, “eng” used to represent English will err. The correct coding for English in the US would be “en-US”

9.6. Automation
- The Clinical Data Repository mapping table, on the OneHealthPort HIE website at this link, provides a current .csv file of CDR entities accepting C-CDAs, their plans, product descriptions and codes for use in building automated triggers to produce C-CDAs.
- Vendors should support the development of a batch or transaction process based on encounters in a given time period (day(s) or week) for C-CDA exchange.
- Vendor should provide the ability for a practitioner to create the appropriately constrained C-CDA on an ad hoc basis and a recurring basis.
- Scripting can be used to move C-CDA document files from the EHR system to the AS2 tool for delivery outbound to the HIE.
## Table of Participating Sponsors, Plans, Products and associated Identifiers:

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Appendix A – ITI-41 (XDS.b) Provide and Register Document Set

Overview:
OneHealthPort will support the ITI-41 Provide and Register Document Set using AS2 secure transport protocol or using Asynchronous Web Services Exchange with certificate exchange. The ITI-41 transaction requirements are detailed in the IHE IT Infrastructure Technical Framework transaction protocols. Appendix W of the IHE IT Infrastructure Technical Framework Volume 2x IHE ITI TF-2X Volume 2 Appendices provides detailed implementation material.

General Assumptions
- Contracted entities submitting XDS.b transactions will submit fully formed and format compliant files
- With either the web services exchange or the AS2 secure transport protocol submission, the HIE will identify the transactions as a Provide and Register Document Set and forward to the Clinical Data Repository for processing
- There are three important sections to the ITI-41: the RegistryPackage, the ExtrinisicObject and the Association

Specific Data Requirements for XDS.b files
- In the RegistryPackage
  - The SubmissionSet.uniqueid must have a globally unique identifier in the ExternalIdentifier value attribute
  - The SubmissionSet.sourceId must include the source organization’s OneHealthPort HIE assigned OID extended with standard document source identifier of .999.5.2.5 in the ExternalIdentifier value attribute with the following format:
    value="1.3.6.1.4.1.38630.2.1.1.10.999.5.2.5"
  - The SubmissionSet.patientID must include the source organization’s patient identifier and the source organization’s OneHealthPort HIE assigned OID appended by the standard namespace identifier of .999.1.1.2 in the ExternalIdentifier value attribute with the following format: “patient identifier^^^&amp;OID.999.1.1.2&ISO”
    Example:
    <ExternalIdentifier value="TST76598^^^&1.3.6.1.4.1.38630.2.1.1.10.999.1.1.2&ISO"
- In the ExtrinisicObject
  - The sourcePatientID value must include the CDR sponsor patient identifier and the CDR Sponsor OID with standard namespace identifier appended in the following format:
    <Value>CDRSponsorPatientIdentifier^^^&CDRSponsorOneHealthPortAssignedOID.999.1.1.2&ISO</Value>
    HealthCare Authority example:
    <Value>123456789WA^^^&1.3.6.1.4.1.38630.3.1.999.1.1.2&ISO</Value>
    If PDQ has been used the global CDR identifier and CDR OID would be used
    <Value>987654^^^&1.3.6.1.4.1.38630.3.999.1.1.2&ISO</Value>
- In the Association
  - The sourceObject attribute must be the same identifier used as the Registry Package unique identifier

Error Processing (TBD)

Sample Transaction (TBD)
Appendix B – ITI-47 Patient Demographic Query/Response

Overview
When patient identifiers are unknown to a provider, the PDQ provides a way to obtain the global patient identifier existing in the CDR for sponsored lives. OneHealthPort will support the PDQ and PDQ Response using AS2 secure transport protocol or using Asynchronous Web Services Exchange with certificate exchange. The PDQ transaction requirements are detailed in the IHE IT Infrastructure Technical Framework transaction protocols. Appendix W of the IHE IT Infrastructure Technical Framework Volume 2x IHE ITI TF-2X Volume 2 Appendices provides detailed implementation material.

General Assumptions
• Contracted entities submitting PDQ transactions will submit properly formatted and fully formed .xml files
• With either the web services exchange or the AS2 secure transport protocol forms of submission, the HIE will identify the transactions as a Patient Demographic Query and forward to the Clinical Data Repository for processing.
• Contracted entities will receive properly formatted and fully formed PDQ .xml response files

Error Processing (TBD)

Sample Transactions:

**PDQ request sample transaction**

```xml
<soap:Envelope xmlns:soap="http://www.w3.org/2003/05/soap-envelope" xmlns:urn="urn:ihe:iti:pdqv3:2007">
  <soap:Header/>
  <soap:Body>
    <PRPA_IN201305UV02 xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance" xmlns="urn:hl7-org:v3" xsi:schemaLocation="urn:hl7-org:v3 ../../schema/HL7V3/NE2008/multicacheschemas/PRPA_IN201305UV02.xsd" ITSVersion="XML_1.0" xmlns:soap="http://www.w3.org/2003/05/soap-envelope">
      <id root="1.2.840.114350.1.13.0.1.7.1.1" extension="35423"/>
      <creationTime value="20160506115601"/>
      <interactionId root="2.16.840.1.113883.1.6" extension="PRPA_IN201305UV02"/>
      <processingCode code="T"/>
      <processingModeCode code="T"/>
      <acceptAckCode code="AL"/>
      <receiver typeCode="RCV">
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          <asAgent classCode="AGNT">
            <representedOrganization determinerCode="INSTANCE" classCode="ORG">
              <id root="1.3.6.1.4.1.38630.3.99.1.2"/>
              <telecom value="http://cdruatmpi1:8080/mpi/ws/iti47Service?wsdl"/>
            </representedOrganization>
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        </receiver>
        <sender typeCode="SND">
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    </PRPA_IN201305UV02>
  </soap:Body>
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            </representedOrganization>
          </asAgent>
        </device>
      </sender>
      </PRPA_IN201305UV02>
    </soap:Body>
  </soap:Envelope>

PDQ request response sample transaction

<soap:Envelope xmlns:soap="http://www.w3.org/2003/05/soap-envelope">
  <soap:Body>
    <PRPA_IN201306UV02 ITSVersion="XML_1.0" xmlns="urn:hl7-org:v3" xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance" xmlns:xsd="http://www.w3.org/2001/XMLSchema">
      <id root="1.3.6.1.4.1.38630.3.99.1.2.1.1.3" extension="cec421df-7060-4c05-a350-77dfff83db85"/>
      <creationTime value="20160609112709"/>
      <interactionId root="2.16.840.1.113883.1.6" extension="PRPA_IN201306UV02"/>
      <processingCode code="P"/>
      <processingModeCode code="T"/>
      <acceptAckCode code="NE"/>
      <receiver typeCode="RCV">
        <device classCode="DEV" determinerCode="INSTANCE">
          <id root="1.3.6.1.4.1.38630.2.1.1.10.999.1.1.2"/>
          <asAgent classCode="AGNT">
            <representedOrganization classCode="ORG" determinerCode="INSTANCE">
              <id root="1.3.6.1.4.1.38630.2.1.1.10.999"/>
            </representedOrganization>
          </asAgent>
        </device>
      </receiver>
      <sender typeCode="SND">
        <device classCode="DEV" determinerCode="INSTANCE">
          <id root="1.3.6.1.4.1.38630.3.99.1.2"/>
          <asAgent classCode="AGNT">
            <representedOrganization classCode="ORG" determinerCode="INSTANCE">
              <id root="1.3.6.1.4.1.38630.3.99.1.2"/>
            </representedOrganization>
          </asAgent>
        </device>
      </sender>
      </PRPA_IN201306UV02>
    </soap:Body>
  </soap:Envelope>
<telecom value="http://cdruatmpi1:8080/mpi/ws/iti47Service?wsdl"/>
</representedOrganization>
</asAgent>
</device>
</sender>
</acknowledgement>
</targetMessage>
</controlActProcess>
</PRPA_IN201306UV02>
</soap:Body>
</soap:Envelope>

In the situation where the CDR sponsor’s patient identifier was not known, and organizations used a PDQ to acquire the CDR global identifier and OID:

If the organization is using the patientRole section of the CDR message header to report the CDR identifiers (First Option above in section 4) the first id extension attribute in the patientRole element must be the CDR global patient identifier and the first id root attribute must be the CDR OID. The second id extension attribute must be the source (submitting) organization’s patient identifier and the second id root attribute must be the OneHealthPort OID assigned to the organization:

**EXAMPLE:**
<patientRole>
  <id extension="987654" root="1.3.6.1.4.1.38630.3"/>
  <id extension="135792468" root="1.3.6.1.4.1.38630.2.1.1.10"/>
</patientRole>

If the organization is using the informationRecipient section of the CDR message header to report the CDR identifiers (SECOND OPTION above in section 4) the id extension attribute in intendedRecipient element must be the CDR global patient identifier and the id root attribute must be the CDR OID

**EXAMPLE:**

```
<informationRecipient>
  <intendedRecipient>
    <id extension="987654" root="1.3.6.1.4.1.38630.3"/>
  </intendedRecipient>
</informationRecipient>
```