ONC Update: Clinical Form Management & Clinical Note

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As part of the ONC HTI-1 certification effort, DrChrono. enhanced its system to support USCDI v3 Health Status Assessments. This will be accomplished by using Clinical Form Management to capture and store structured health concern data. The updates allow clinicians and care teams to document patient concerns in a standardized, interoperable way.

Why the Updates | What has Changed | Requirements | Additional Updates

Related articles

- (ONC Update) Clinical Test or Result Form Element
- (ONC Update) Health Concern Assessment
- (ONC Update) Planned Procedure Form Element
- (ONC Update) Pregnancy Status
- (ONC Update) Smoking Status
- ONC HTI-1 Updates: USCDI v3

Why This Update Matters

- **Regulatory Compliance**: This enhancement ensures DrChrono aligns with ONC HTI-1 and USCDI v3 requirements, a critical step toward 2025 certification.
- **Patient-Centered Care**: By capturing what's important or concerning to the patient, family, or provider, the system supports more holistic, personalized care.
- **Structured Data for Interoperability**: Adding SNOMED CT and LOINC codes enables the use of standardized terminology, improving data consistency across systems and simplifying data sharing in the CCDA.

What Has Changed

- **Form Builder Integration**: Health status assessments are now supported through customizable form templates, allowing structured data capture.
- **Terminology Support**: Questions and responses within health status forms now include SNOMED CT and LOINC codes for standardized documentation.
- **Form Packets Introduced**: Predefined form types (form packets) streamline data entry and enable easier integration of health status data into Consolidated Clinical Document Architecture (CCDA) exports.

Requirements and Updates

Requirement	Update

Update Form Type Options and Add CCDA Category Field	- Renamed the 'Form Type' field to CCDA Clinical Note Type. - Dropdown menu includes the following options: - Consultation Note - Discharge & Summary Note - History & Physical Note - Procedure Note - Progress Note - The following items in the dropdown menu will display as "inactive": - Laboratory Report Narrative - Pathology Report Narrative - Diagnostic and Imaging Study
Rename Billing Code Attachment	The new label is Code Attachment
Add LOINC and SNOMED codes to Billing Code Attachment section	Previously, the Clinical Form Management allowed users to add billing codes like CPT, Custom, HCPCS, and ICD-10. We improved this feature by also allowing users to link LOINC and SNOMED codes, making it easier to include standardized clinical information in forms.

Add USCDI v3 Health Assessments to Form Library	To meet USCDI v3 requirements, we needed to support health assessments using LOINC codes. These assessments were included in the patient's CCDA file to make sure the data could be shared properly between different systems.
	
	We used our existing Form Library to support these assessments. They were made available under Clinical> Form Tools > Library. Each form was prebuilt with the correct LOINC codes, allowing users to easily preview a form and add it to their clinical note.
	
	The Assessment Form Table will display a list of available prebuilt health assessments sourced from LOINC. The table will include the following columns:
	• Assessment Name – The title of the assessment panel
	• Publish Date – The date the assessment was published
	• Rating – Optional user rating for the form
	• Actions
	
	    ○ Preview Form – Opens a read-only modal view of the form for review
	
	    ○ Use Form – Adds the selected form to the Form Builder for the current practice
	
	• The table supports pagination, viewing 30 forms per page. Users can paginate through the assessment forms using forward and back arrows.

Create a New Form Element for Clinical Field	Added a new form element in Clinical Form Management called "Clinical Field." This new field lets users include structured clinical information in a form that will be added to a patient's CCDA file. When users add a Clinical Field to a form, they can choose to set it up to collect one of the following types of clinical data: • Clinical Test or Result • Pregnancy Status • Smoking Status • Planned Procedure
Clinical Test or Result	Learn more about Clinical Test or Result Form Element.
Planned Procedure	Learn more about Planned Procedure Form Element

Health Concern Assessment	Learn more about (ONC Update) Health Concern Assessment
Pregnancy Status	Learn more about (ONC Update) Pregnancy Status
Smoking status	Learn more about (ONC Update) Smoking Status
CCDA Observation Type	Form type field to renamed to CCDA Clinical Note Type Dropdown menu includes the following options: - Consultation Note - Discharge & Summary Note - History & Physical Note - Procedure Note - Progress Note The following items in the dropdown menu will display as "inactive": - Laboratory Report Narrative - Pathology Report Narrative - Diagnostic and Imaging Study

Additional Updates

CCDA Clinical Note Settings

New settings have been added to allow providers to define where their CCDA Note is pulled from and the default type of CCDA Clinical Note.

Provider Account Settings (General > Clinical Note section):

1. **"Default CCDA Clinical Note Source"** setting - A single select dropdown with the following options:

   - Form Builder (default - current behavior)

   - Appointment Profile

2. **"Default CCDA Clinical Note Type"** setting - A single select dropdown with the following options:

   - Consultation Note

   - Discharge & Summary Note

   - History & Physical Note

   - Procedure Note

   - Progress Note

3. **"Do Not Disclose in CCDA"** checkbox - When checked, the clinical note will not be included in the CCDA. This is intended for behavioral health or psychotherapy notes that should not be shared in a patient's record.

Appointment Profile Settings (Account > Custom Fields > Appointment Profiles):

1. **"Default CCDA Clinical Note Type"** setting - Same dropdown options as Provider Account Settings

2. **"Do Not Disclose in CCDA"** checkbox - Same functionality as Provider Account Settings

Billing Code Support for Text Fields

Billing codes such as CPT, Custom, ICD-10, and HCPCS, which were previously limited to multi-select and single-select form elements, now support Text Field form elements as well.

Archive Form Icon Update

The Archive Icon on the Clinical Form Management screen has been updated to be more intuitive.