Recommendations Regarding the Use of Standard Nursing Terminology in Minnesota

Introduction

Health informatics standards continue to evolve; therefore standards recommended for use in Minnesota are regularly reviewed and updated by the Minnesota e-Health Initiative and are approved by the Minnesota Department of Health (MDH). Under Minnesota Statutes 62J.495 Subd. 1. the Commissioner of Health is authorized to specify uniform standards requirements for achieving interoperable electronic health records (EHRs).

MDH has published recommended standards for interoperable electronic health record requirements and transactions such as: electronic prescribing, laboratory results reporting, immunization information exchange, and recommended standards and resources for achieving meaningful use. Current standards recommendations and additional resources are available online at http://www.health.state.mn.us/e-health/standards/index.html.

Need for Nursing Terminology Standards

The Minnesota e-Health Standards and Interoperability Workgroup identified several reasons for recommending nursing terminology standards, including:

- It is commonplace for patients to move between health care settings and with that there is a need for information to move with them
- Standard Nursing terminologies are needed for better assessment, diagnosis and treatment of individual patients
- Although there are many nursing terminologies in use, some of which are well suited for specific settings, there is currently no single national nursing terminology standard

Recommendations Regarding Use of Nursing Terminologies

On May 22, 2014 the Minnesota e-Health Advisory Committee voted to adopt the Standards and Interoperability Workgroup's findings and recommendations regarding the need for standardized nursing terminology in health and health care settings. The following recommendations have been approved by the Commissioner of Health and will be incorporated in the next edition of the Minnesota e-Health Standards and Interoperability Guide.

1. All health and health care settings should create a plan for implementing an American Nursing Association (ANA) recognized terminology within their electronic health record (EHR).
2. Each health and health care setting type should achieve consensus on an ANA recognized standard terminology that best suits its needs and select that terminology for its EHR, either individually or collectively as a group (e.g. EHR user group).

3. Education should be provided and guidance be developed for selecting the terminology standard that suits the needs for a specific health and health care setting.
4. When exchanging a Consolidated Clinical Document Architecture (C-CDA) document with another setting for problems and care plans, SNOMED-CT and LOINC terminologies should be used for exchange.
5. The Omaha System terminology for exchange between public health or community-based settings for reporting of results should be used where appropriate (e.g. two public health agencies or a public health and home care agency that both use the Omaha System). Exchange between providers that do not use the Omaha System and a provider that does will require a common terminology for exchange which should be SNOMED-CT and LOINC.

MDH adopted these recommendations on August 6, 2014 and encourages regional and national organizations to support the national adoption of standard nursing terminologies.

For more information, contact:

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