Integrating the Healthcare Enterprise

5

IHE PCC

Technical Framework Supplement

10

Patient Plan of Care
(PPOC)

Public Comment

15

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This is a supplement to the IHE PCC Technical Framework V4.0

It is submitted for Public Comment between June 1, 2009 and July 1, 2009.

Comments shall be submitted within that period to http://forums.rsna.org:

1. Select the "IHE" forum
2. Select PCC Technical Framework
3. Select 2009-2010 Supplements for Public Comment
4. Select Patient Plan of Care

Please use the Public Comment Template provided when starting your New Thread.

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http://www.ihe.net/Technical_Framework/index.cfm

These "boxed" instructions are for the author to indicate to the Volume Editor how to integrate the relevant section(s) into the overall Technical Framework

Replace Section X.X by the following:

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Introduction

This supplement adds the Patient Plan of Care Profile to Volume I of the IHE PCC Technical Framework, and the Patient Plan of Care Document Content Module and related modules to Volume II.

Profile Abstract

The Patient Plan of Care profile (PPOC) extends the description of the content structures for the plan of care in the current technical framework and is based on the data elements from the Nursing Process currently in common use. The PPOC includes the following additional components in a clinical document:

1. Assessment
2. Diagnosis
3. Outcomes Identification
4. Planning
5. Implementation
6. Evaluation

This profile defines the implementation of HL7 CDA documents to represent these data elements along with the XDS, XDR and XDM bindings. The Patient Plan of Care is a content profile that is intended to eventually sit within a larger folder structure that contains documents related to continuity of care for the patient. This profile also defines mechanisms to group them into a single logical folder.

The Plan of Care (PPOC) profile provides a mechanism for electronic exchange of plan of care data between and among HIT systems. The PPOC demonstrates the exchange of this information based on concepts for diagnoses, interventions, and outcomes in a standardized framework using the American Nurses Association (ANA) nursing process to evolve its information model.

Open Issues and Questions

< List of open issues/ questions that need to be addressed prior to publishing of the Technical Framework>

Closed Issues

< List of closed issues/ questions with their resolutions that have been addressed prior to publishing of the Technical Framework>

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Volume 1 – Integration Profiles

Glossary

100 **Standards of Practice**: The six Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the **nursing process**. The **nursing process** includes the components of assessment, diagnosis, outcomes identification, planning, implementation and evaluation. The nursing process encompasses all significant actions taken by registered nurses, and forms the foundation of the nurse's decision making" (ANA, 2004, p.4).

105 Standard 1: Assessment:

The registered nurse collects comprehensive data pertinent to the patient's health or the situation.

Standard 2: Diagnosis:

The registered nurse analyzes the assessment data to determine the diagnoses or issues.

Standard 3 Outcomes Identification:

110 The registered nurse identifies expected outcomes for a plan individualized to the patient and situation.

Standard 4: Planning:

The registered nurse develops a plan then prescribes strategies and alternatives to attain expected outcomes.

115 Standard 5:Implementation:

The Registered nurse implements the identified plan

Standard 6: Evaluation

The registered nurse evaluates the progress toward attainment of outcomes.

2.5 Dependencies among Integration Profiles

120 *Add the following to Table 2-5*

Integration Profile	Dependency	Dependency Type	Purpose
Patient Plan of Care (PPOC)	Functional Status Assessments (FSA)	The Content Creator and Content Consumer actors of the PPOC profile shall be grouped with Content Creator and Content Consumer actors of the FSA profile respectively.	The PPOC profile makes use of content modules defined within the FSA profile.

2.7 History of Annual Changes

Add the following bullet to the end of the bullet list in Section 2.7

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In the 2009-2010 cycle of the Patient Care Coordination Initiative, the following content profile was added as a supplement to the technical framework.

- Added the Patient Plan of Care Profile (PPOC) that extends the description of the content structures for the plan of care in the current technical framework and is based on the data elements from the Nursing Process currently in common use.

Add Section X

X Patient Plan of Care Content Profile

The fundamental building block of any high-performance health system is reliable information about the effectiveness of care (O'Kane, et.al, 2008). Nurses act as the coordinator of care for the whole care process. However, standardized coded documentation by nursing is one of the largest data gaps in care delivery. Furthermore, nursing documentation of the human response to actual or potential health threats can rarely be transferred electronically at the current time.

The Patient Plan of Care (PPOC) profile provides a mechanism for capture and electronic exchange of plan of care data between and among HIT systems. This profile enables the exchange of this information based on concepts for diagnoses, interventions, and outcomes in a standardized framework using the American Nurses Association (ANA) nursing process to evolve its information model. It is also informed by models of care used in the Clinical Care Classification (CCC) System, and can convey the concepts found in that and other controlled vocabularies.

These models extend the description of the content structures for the plan of care in the current technical framework. The Patient Plan of Care focuses on the following six components in a clinical document:

1. Assessment
2. Nursing Diagnosis
3. Outcomes Identification
4. Planning
5. Implementation
6. Evaluation

The components of the process are shown in Figure X-1 below. When a patient arrives for care (e.g., upon admission or transfer of care) they undergo an initial assessment. The care planning process includes diagnoses, outcomes identification (goals), and the planning of care with the patient or their advocate. The nursing process continues with the nurse providing care. This results in actions performed to care for the patient, followed by evaluation of the patient progress against the expected outcomes. Evaluation measures the current patient progress against the expected outcomes through subsequent assessments. These assessments are then used to adjust the nursing process. These components are performed continuously through the nursing process at macro- and micro- levels.

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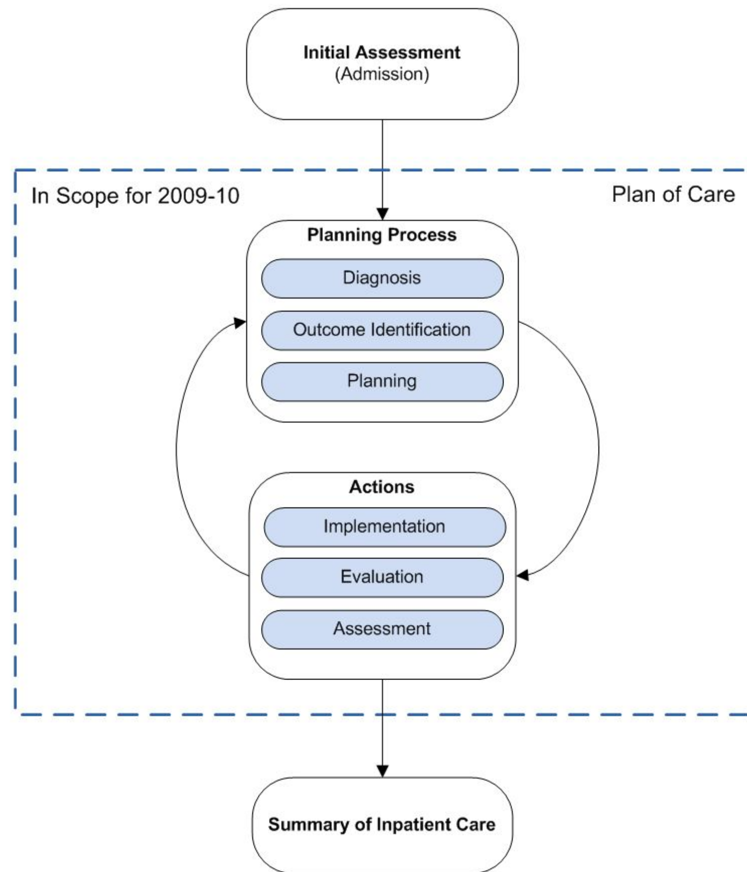

Figure X-1 Nursing Process

This profile defines the implementation of an HL7 CDA document to represent the data elements needed for care planning, along with the IHE profile bindings to support the exchange of the information. The Patient Plan of Care is a content profile that is intended to eventually sit within a larger folder structure that contains documents related to continuity of care for the patient. This profile also defines mechanisms to group them into a single logical folder.

Regardless of where nurses practice, the Patient Plan of Care (PPOC) Profile is able to support coded nursing documentation. This allows healthcare organizations to access quality data on the complexity of patient conditions and the care performed by professional nurses, improve care quality, and facilitate continuity of care.

Use Case

A 70 year old male is admitted to a hospital unit after presenting to the Emergency Department with productive cough, acute rib pain, increased work of breathing, pulse oximetry saturation of 88%, temperature of 102.2 degrees, heart rate of 108, and blood pressure of 156/88. Chest x-ray done in ED showed bilateral lower lobe and right middle lobe infiltrates. Medical diagnosis is Pneumonia.

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180 ## X.1 Actors and Transactions

There are two actors in this profile, the Content Creator and the Content Consumer. Content is created by a Content Creator and is to be consumed by a Content Consumer. The sharing or transmission of content from one actor to the other is addressed by the appropriate use of IHE profiles described below, and is out of scope of this profile. A Document Source or a Portable
185 Media Creator may embody the Content Creator Actor. A Document Consumer, a Document Recipient or a Portable Media Importer may embody the Content Consumer Actor. The sharing or transmission of content or updates from one actor to the other is addressed by the use of appropriate IHE profiles described by section 3.7 Content Bindings with XDS, XDM and XDR found in the Patient Care Coordination Technical Framework

190

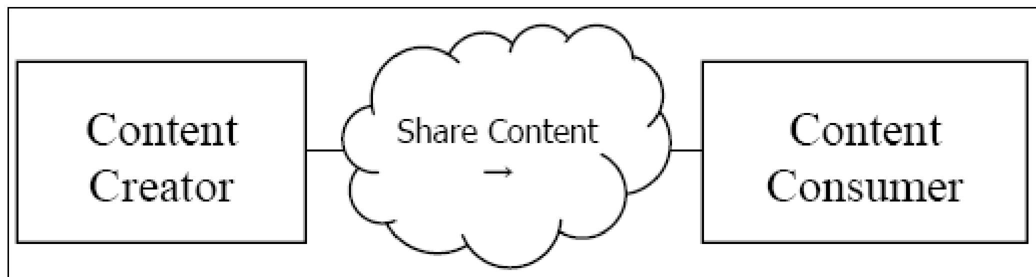

Figure X.1-2 Patient Plan of Care Actors and Transactions

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Transfer of Care

Content Creator

- **Nursing Initial assessment received (out of scope)**
- **Documentation of Patient Plan of Care (PPOC):**
- **Nursing Diagnosis**
- **Outcomes Identified**
- **Planning**
- **Implementation**
- **Evaluation**
- **Follow up assessment (out of scope)**

Content Consumer / Creator

- **Nurse Reviews and Implements plan of care**
- **Follow up assessment (out of scope)**
- **Evaluation of progress toward outcomes**
- **Planned PoC update**
- **Add, maintain or closure of diagnosis, goals met, or no longer needed interventions**
- **Transfer of PPOC including remaining diagnosis, goals or interventions in case of change in provider or facility**

195

X.2 Patient Plan of Care Options

Actor	Option	Section
Content Consumer	View Option (See Note 1) Document Import Option (See Note 1) Section Import Option (See Note 1) Discrete Data Import Option (See Note 1)	PCC TF-2: 3.0.1 PCC TF-2: 3.0.2 PCC TF-2: 3.0.3 PCC TF-2: 3.0.4
Content Creator	None	

Note 1: The Actor shall support at least one of these options.

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X.3 Grouping

This section describes the behaviors expected of the Content Creator and Content Consumer actors of this profile when grouped with actors of other IHE profiles.

X.3.1 Content Bindings with XDS, XDM and XDR

It is expected that the exchanges of this content will occur in an environment where the physician offices and hospitals have a coordinated infrastructure that serves the information sharing needs of this community of care. Several mechanisms are supported by IHE profiles:

- A registry/repository-based infrastructure is defined by the IHE Cross Enterprise Document Sharing (XDS) and other IHE Integration Profiles such as patient identification (PIX & PDQ) and notification of availability of documents (NAV).
- A media-based infrastructure is defined by the IHE Cross Enterprise Document Media Interchange (XDM) profile.
- A reliable messaging-based infrastructure is defined by the IHE Cross Enterprise Document Reliable Interchange (XDR) profile.
- All of these infrastructures support Security and privacy through the use of the Consistent Time (CT) and Audit Trail and Node Authentication (ATNA) profiles.

For more details on these profiles, see the IHE IT Infrastructure Technical Framework. Content profiles may impose additional requirements on the transactions used when grouped with actors from other IHE Profiles.

X.3.2 Cross Enterprise Document Sharing, Media Interchange and Reliable Messages

Actors from the ITI XDS, XDM and XDR profiles most often embody the Content Creator and Content Consumer sharing function of this profile. A Content Creator or Content Consumer may be grouped with appropriate actors from the XDS, XDM or XDR profiles, and the metadata sent in the document sharing or interchange messages has specific relationships to the content of the clinical document described in the content profile.

X.3.3 Audit Trail and Node Authentication (ATNA)

When the Content Creator or Content Consumer actor of this profile is grouped with the Secure Node or Secure Application actor of the ATNA profile, the content creator actor shall generate appropriate audit record events for each of the following trigger events:

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Trigger Event	Description
Actor-start-stop	Start up and shut-down of the content creator or content consumer actor.
Patient-Record-Event	Creation, access, modification[1] or deletion of the content described within this profile.
Node-Authentication-Failure	Secure node authentication failure is detected.

Figure X.3: Minimum Trigger Event Set

235 The above list is a minimum set that must be demonstrated by all actors of this profile when grouped with the secure node or secure application actor. Additional audit records shall also be generated depending upon the actions available the product implementing the secure node or secure application actor.

X.3.4 Notification of Document Availability (NAV)

240 A Document Source should provide the capability to issue a Send Notification Transaction per the ITI Notification of Document Availability (NAV) Integration Profile in order to notify one or more Document Consumer(s) of the availability of one or more documents for retrieval. One of the Acknowledgement Request options may be used to request from a Document Consumer that an acknowledgement should be returned when it has received and processed the notification.

245 A Document Consumer should provide the capability to receive a Receive Notification Transaction per the NAV Integration Profile in order to be notified by Document Sources of the availability of one or more documents for retrieval. The Send Acknowledgement option may be used to issue a Send Acknowledgement to a Document Source that the notification was received and processed.

250 X.3.5 Document Digital Signature (DSG)

When a Content Creator Actor needs to digitally sign a document in a submission set, it may support the Digital Signature (DSG) Content Profile as a Document Source. When a Content Consumer Actor needs to verify a Digital Signature, it may retrieve the digital signature document and may perform the verification against the signed document content.

255 X.4 Content Modules

Content Modules describe the content of a payload found in an IHE transaction. Content profiles are transaction neutral. They do not have dependencies upon the transaction in which they appear. This integration profile defines one content module, the Patient Plan of Care, defined in section PCC TF-2:6.1.1.Y.

260 While the Patient Plan of Care focuses on the nursing process. It is intended to be a summary document containing the necessary information for the care planning process.

[1] Clinical documents are not normally modified after being finalized. However, prior to that event one or more parties may author the content in stages. Each subsequent stage should be treated as a modification of the previous stage.

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This content module incorporates other content modules already present in this Technical Framework. The names of these content modules do not always use the terminology found in nursing (e.g., Review of Systems). However, the data elements found in these sections are identical in content regardless of the scope of practice for the clinician providing that information.

The purpose of section is to identify the type of information found in it. The clinician generating this information is separately identified within the content module. Those two pieces together provide sufficient information to interpret the content.

X.5 Patient Plan of Care Process Flow

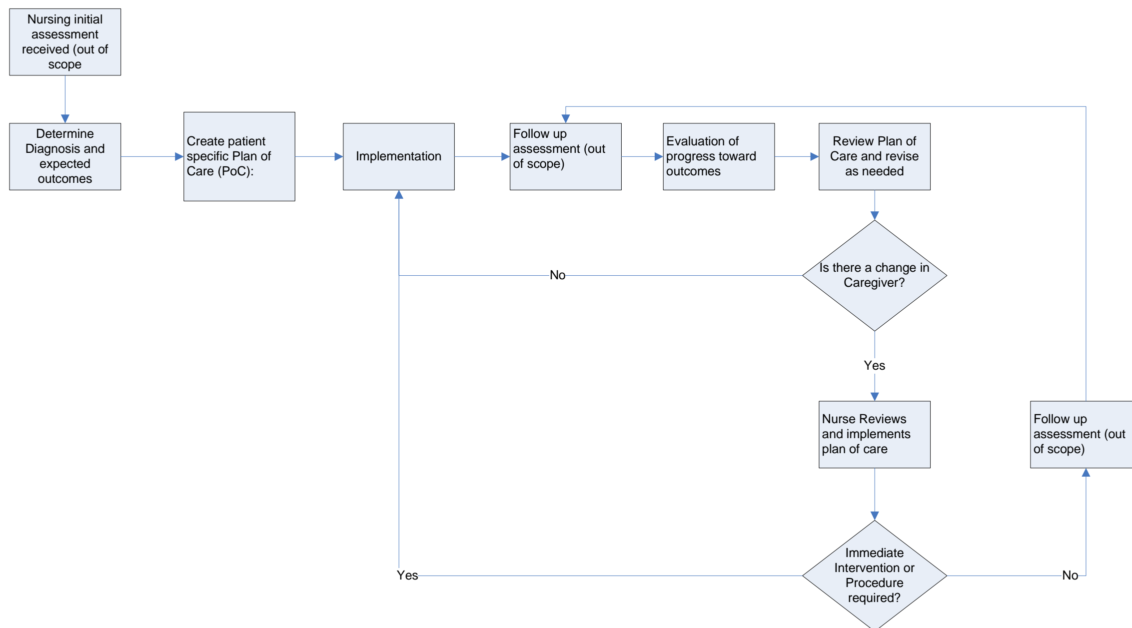

Figure X.3.1: Patient Plan of Care Process Flow

This process flow diagram shows the movement of the Patient Plan of Care over the course of care for a patient as an inpatient on a Nursing Unit. This diagram specifically excludes other infrastructure interactions for simplicity and readability. These infrastructure interactions may be found elsewhere in this and other IHE frameworks.

The data from a Patient Plan of Care are exchanged electronically between and among health technology information systems for each of the steps of the Nursing Process. The Plan of Care may also be exchanged with consultants and other interested providers who may then update the Patient Plan of Care, and return the updated record to the sender, primary care provider, patient, and/or other interested providers.

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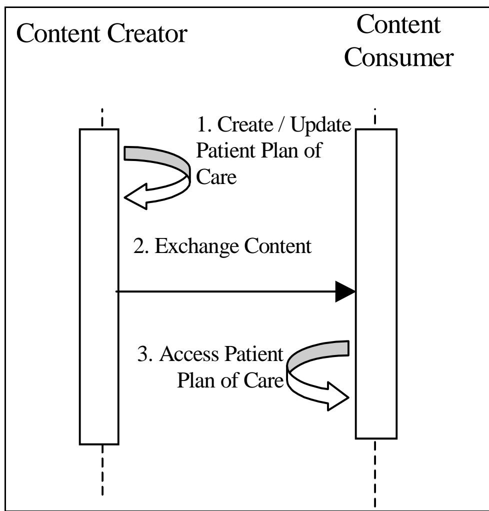

285

Figure X.3-2. Basic Process Flow in the Patient Plan of Care Profile

The following steps show the use of the Patient Plan of Care Profile during the nursing process.

1. A patient admitted as an inpatient to a hospital for a clinical diagnosis or a surgical procedure requires nursing care. A nurse reviews the clinician orders and develops an individualized Plan of Care with the patient based on the Nursing Process. This model includes medical and nursing orders within the electronic health record (EHR) system. The Nurse documents a specific Plan of Care using coded nursing terminology.
2. The plan of care is stored within an HIT system.[2]
3. The Patient Plan of Care is active as long as the patient remains an inpatient and until the patient is discharged or transferred. During the inpatient stay, the nurses review the patient's plan of care frequently to ensure progress and quality care are maintained and nursing actions are evaluated. When there is a change in the patient's clinical condition the Patient Plan of Care is revised as needed.

The following describes these same steps used in the context of a transfer of care.

1. When a patient is transferred to another facility the Patient Plan of Care is revised for the continuity of care.
2. The updated patient plan of care is exchanged with the destination facility.
3. The plan of care is reviewed at the destination facility and is updated as needed.

X.6 Patient Plan of Care Security Considerations

<Description of the Profile specific security considerations. This should include the outcomes of a risk assessment. This likely will include profile groupings, and residual risks that need to be assigned to the product design, system administration, or policy.>

[2] This step does not always involve and exchange between different HIT systems.

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310 Reference:

American Nurses Association. (2004). *Nursing: Scope & Standards of Practice*. Silver Spring, MD. ANA.

O'Kane, M., Corrigan, J., Foote, S.M., Tunis, S.R., Isham, G.J., Nichols, L.M., Fisher, E.S., Ebeler, J.C., Block, J.A., Bradley, B.E., Cassel, C.K., Ness, D.L., Tooker, J. Crossroads in
315 Quality. Health Affairs (Millwood). 2008 May-Jun. 27(3). 749-58.

Saba, V. (2007). *Clinical Care Classification (CCC) System Manual: A Guide to Nursing Documentation.* Springer. NY, NY.

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Volume 2 – Transactions and Content

320

Add Section 6.1.1.Y to the end of Section 6.1.1

6.1.1 CDA Document Content Modules

6.1.1.Y Care Plan Specification 1.3.6.1.4.1.19376.1.5.3.1.1.20.1.1

The nursing evaluation and management note contains the information relevant to the six
325 components of the nursing process described by the American Nursing Association Standards of Nursing Practice (ANA 2004). These include:

- Assessment
  The assessment includes the collection of data pertinent to the patient's health. This assessment may include review of systems and/or physical examination details and vital
  330 signs, functional status or potential risks to the patient. Additional sections may be added to include relevant family / social history, or other key knowledge necessary to the implementation of the nursing plan.
- Nursing Diagnosis
  The problem list section includes any diagnoses based on assessment data and information
  335 received from other providers.
- Expected Outcomes
  Identification of individualized expected outcomes for the patient (the goals)
- Planning
  Planning is the stage in the process to prescribe treatments and interventions to be
  340 implemented to reach the expected outcomes under the plan. Planning includes patient/advocate expectations.
- Implementation
  Implementation of the plan includes the actions and interventions performed along with care provided to the patient.
- 345 Evaluation
  Evaluation of the effectiveness of the plan moving the patient toward goal attainment of the predicted outcomes by documentation of patient response to the plan of care implementation.

  In addition to these sections, the care plan also includes other information relevant to the planning process, including the following:

- 350 Orders
  The care plan must include a section referencing provider orders and actions that are to be implemented, including any orders for treatment (e.g., medications, therapy, et cetera), monitoring (testing, monitoring, et cetera) or education.
- Allergies
  355 The care plan must document the presence or absence of patient allergies.

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- Past Medical History
  The care plan shall include past medical history relevant to care planning
- Surgical History
  The care plan shall include any relevant prior surgical history.
- Advance Directives
  The care plan shall include information about any relevant advance directives or note their absence.
- Immunizations
  The care plan should include information about the patient's immunization status (e.g., recent flu shot).
- Family and Social History
  The care plan may include information about relevant family and social history pertinent to care planning.

The document content module specifies which IHE templates to use for each of the above components. However, the sections described above are not necessarily an exhaustive list of all necessary sections. Additional information may be required based on the context of the care being provided. For example, when treating a patient in a labor and delivery setting, information such as the patient's pregnancy history would be needed. The IHE PCC Technical framework contains a library of section templates that may be used within this document content module.

6.1.1.Y.1 LOINC Code

The LOINC code for this document is 34746-8 Nursing Evaluation and Management Note

6.1.1.Y.2 Standards

CDAR2 HL7 CDA Release 2.0

CCD ASTM/HL7 Continuity of Care Document

ANA 2004 ANA Nursing Scope and Standard of Practice

6.1.1.Y.3 Data Element Index

Data Element	LOINC	ANA 2004
Assessment	X-ASSESS ASSESSMENTS	Assessment
Physical Examination	29545-1 PHYSICAL EXAMINATION	Assessment
Review of Systems	10187-3 REVIEW OF SYSTEMS	Assessment
Functional Status Assessment	47420-5 FUNCTIONAL STATUS ASSESSMENT	Assessment
Family History	10157-6 HISTORY OF FAMILY MEMBER DISEASES	Assessment
Social History	29762-2 SOCIAL HISTORY	Assessment

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Active Problems	11450-4 PROBLEM LIST	Diagnosis
Allergies	48765-2 Allergies, adverse reactions, alerts	Diagnosis
Goals	X-OUTCOME Outcome Identification	Outcome Identification
Care Plan	18776-5 Plan of Treatment	Planning
Provider Orders	46209-3 PROVIDER ORDERS	Planning
Advance Directives	42348-3 ADVANCE DIRECTIVES	Planning
Procedures and Interventions	29544-3 PROCEDURES	Implementation
Medications Administered	18610-6 MEDICATION ADMINISTERED	Implementation
Fluids Administered	8975-5 INTRAVASCULAR FLUID INTAKE	Implementation
Progress	27574-3 Progress Note and Attainment of Goals	Evaluation
History of Past Illness	11348-0 HISTORY OF PAST ILLNESS	
Surgical History	47519-4 HISTORY OF PROCEDURES	

6.1.1.Y.4 Specification

380 This section references content modules using Template ID as the key identifier. Defintions of the modules are found in either:

- IHE Patient Care Coordination Volume 2: Final Text
- IHE PCC Content Modules 2009-2010 Supplement (For Public Comment)

Data Element Name	Opt	Template ID
Assessments This section shall include all assessments performed.	R	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.4
Physical Examination The physical examination section shall be present when a physical examination is performed during the assessment of the patient.	C	1.3.6.1.4.1.19376.1.5.3.1.1.9.15
Review of Systems The review of systems section shall be present when a review of systems is performed during the assessment of the patient.	C	1.3.6.1.4.1.19376.1.5.3.1.3.18
Functional Status Assessment This section shall be present when any assessments of functional status were performed on on the patient.	C	1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1
Family History	O	1.3.6.1.4.1.19376.1.5.3.1.3.14
Social History	O	1.3.6.1.4.1.19376.1.5.3.1.3.16
Active Problems The problem list section includes any nursing and physician diagnoses that are relevant to or being treated by the care plan.	R	1.3.6.1.4.1.19376.1.5.3.1.3.6
Allergies and Other Adverse Reactions Section This section shall be present and record the presense or absense of any allergies.	R	1.3.6.1.4.1.19376.1.5.3.1.3.13

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Care Plan The care plan section contain a description of the care requirements.	R	1.3.6.1.4.1.19376.1.5.3.1.3.31
Provider Orders References any orders that are to be implemented, including those for treatment (e.g., medications, therapy or therapeutic encounters, et cetera), monitoring (testing, monitoring, et cetera), or education.	R	1.3.6.1.4.1.19376.1.5.3.1.1.20.2.1
Advance Directives Section This section shall be present and record the presence or absense of any advance directives.	R	1.3.6.1.4.1.19376.1.5.3.1.3.34
Procedures and Interventions This section shall be present when procedures and interventions have been performed.	C	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11
Medications Administered This section shall be present when medications have been administered.	C	1.3.6.1.4.1.19376.1.5.3.1.3.21
Fluids Administered This section shall be present when fluids have been administered.	C	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6
History of Past Illness Section This section shall be present when there is relevant history of past illness.	C	1.3.6.1.4.1.19376.1.5.3.1.3.8
Coded List of Surgeries Section This section shall be present when there is relevant surgical history.	C	1.3.6.1.4.1.19376.1.5.3.1.3.12
Immunizations Section This section shall be present to record relevant immunization status.	C	1.3.6.1.4.1.19376.1.5.3.1.3.23

385

6.1.1.Y.5 Conformance

CDA Release 2.0 documents that conform to the requirements of this content module shall indicate their conformance by the inclusion of the appropriate <templateId> elements in the header of the document. This is shown in the sample document below.

390 **Sample Care Plan Document**

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```xml
<ClinicalDocument xmlns='urn:hl7-org:v3'>
 <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3"/>
 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.1.1'/>
 <id root=' ' extension=' '/>
 <code code='34746-8' displayName='Nursing Evaluation and Management Note'
  codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>
 <title>Care Plan</title>
 <effectiveTime value='20090506012005'/>
 <confidentialityCode code='N' displayName='Normal'
  codeSystem='2.16.840.1.113883.5.25' codeSystemName='Confidentiality' />
 <languageCode code='en-US'/>
   :
 <component><structuredBody>
  <component>
   <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.4'/>
    <!-- Required Assessments Section content -->
   </section>
  </component>

  <component>
   <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15'/>
    <!-- Conditional Physical Examination Section content -->
   </section>
  </component>

  <component>
   <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.18'/>
    <!-- Conditional Review of Systems Section content -->
   </section>
  </component>

  <component>
   <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1'/>
    <!-- Conditional Functional Status Assessment Section content -->
   </section>
  </component>

  <component>
   <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.14'/>
    <!-- Optional Family History Section content -->
   </section>
  </component>

  <component>
   <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.16'/>
    <!-- Optional Social History Section content -->
   </section>
  </component>

  <component>
   <section>
    <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.6'/>
    <!-- Required Active Problems Section content -->
   </section>
  </component>

  <component>
   <section>
```

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```
455        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.13'/>
           <!-- Required Allergies and Other Adverse Reactions Section Section content -->
         </section>
       </component>

460    <component>
         <section>
           <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.31'/>
           <!-- Required Care Plan Section content -->
         </section>
465    </component>

       <component>
         <section>
           <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.2.1'/>
470        <!-- Required Provider Orders Section content -->
         </section>
       </component>

       <component>
475      <section>
           <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.34'/>
           <!-- Required Advance Directives Section content -->
         </section>
       </component>
480
       <component>
         <section>
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           <!-- Conditional Procedures and Interventions Section content -->
485      </section>
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490        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.21'/>
           <!-- Conditional Medications Administered Section content -->
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495    <component>
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505        <!-- Conditional History of Past Illness Section Section content -->
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510      <section>
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           <!-- Conditional Coded List of Surgeries Section Section content -->
         </section>
       </component>
515
       <component>
         <section>
           <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.23'/>
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520      <!-- Conditional Immunizations Section Section content -->
        </section>
      </component>


  </structuredBody></component>
525 </ClinicalDocument>
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