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IHE Patient Care Coordination (PCC) Technical Framework Supplement

10

Patient Plan of Care (PPOC)

Trial Implementation

15

20 Date: September 9, 2011
Author: Keith W. Boone
Email: pcc@ihe.net

Foreword

25 This is a supplement to the IHE Patient Care Coordination Technical Framework V7.0. Each supplement undergoes a process of public comment and trial implementation before being incorporated into the volumes of the Technical Frameworks.

This supplement is submitted for Trial Implementation as of September 9, 2011 and will be available for testing at subsequent IHE Connectathons. The supplement may be amended based on the results of testing. Following successful testing it will be incorporated into the PCC Technical Framework. Comments are invited and can be submitted at <http://www.ihe.net/pcc/pcccomments.cfm> or by email to pcc@ihe.net.

35 This supplement describes changes to the existing technical framework documents and where indicated amends text by addition (**bold underline**) or removal (~~**bold strikethrough**~~), as well as addition of large new sections introduced by editor’s instructions to “add new text” or similar, which for readability are not bolded or underlined.

“Boxed” instructions like the sample below indicate to the Volume Editor how to integrate the relevant section(s) into the relevant Technical Framework volume:

40

<i>Replace Section X.X by the following:</i>
--

General information about IHE can be found at: www.ihe.net

Information about the IHE QRPH domain can be found at:
<http://www.ihe.net/Domains/index.cfm>

45 Information about the structure of IHE Technical Frameworks and Supplements can be found at:
<http://www.ihe.net/About/process.cfm> and <http://www.ihe.net/profiles/index.cfm>

The current version of the IHE Technical Framework can be found at:
http://www.ihe.net/Technical_Framework/index.cfm

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Introduction

85 This supplement adds the Patient Plan of Care (PPOC) Profile to Volume 1 of the IHE PCC Technical Framework, and the Patient Plan of Care Document Content Module and related modules to Volume 2.

Profile Abstract

90 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
- 95 4. Planning
5. Implementation
6. Evaluation

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

105 The PPOC profile provides a mechanism for electronic exchange of data related to creating and managing individualized patient care 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

110 **Closed Issues**

Volume 1 – Integration Profiles

Glossary

115 **Standards of Practice:** The American Nurses Association defines Standards of Practice as follows¹:

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.

Standard 1: Assessment:

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

125 Standard 2: Diagnosis:

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

Standard 3: Outcomes Identification:

130 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.

Standard 5: Implementation:

135 The Registered nurse implements the identified plan

Standard 6: Evaluation:

The registered nurse evaluates the progress toward attainment of outcomes.

2.5 History of Annual Changes

<i>Add the following bullet to the end of the bullet list in Section 2.5</i>
--

140 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 PPOC Profile 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.

¹ American Nurses Association (2004). *Standards of Clinical Nursing Practice*. Washington, DC: ANA

145 *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.² Nurses act as the 24 hour coordinator of care for the entire inpatient care process. The Patient Plan of Care is an individualized, mutually agreed upon plan. This PPOC Profile describes the contribution of Registered Nurses to the plan. The plan includes problem issues (nursing diagnoses), expected healthcare outcomes, implementable interventions, and evaluation of progress toward outcomes based on follow up assessment. It is a framework to document critical thinking necessary for excellent evidenced based outcomes.

Each healthcare discipline provides a plan agreed upon with the patient/advocate, based on license and the discipline's scope of practice. Future work is expected to add contributions to PPOC from each healthcare profession.

Standardized coded documentation by nursing is one of the largest data gaps in care delivery. Furthermore, nursing documentation of non- numeric human responses to actual or potential health threats are infrequently transferred electronically at the current time.

This PPOC content profile scope contains five of the six components of the nursing process to document human response. The assessment information, as described in the use case, is added to support a depiction of change in health status leading to patient admission, discharge and transfer to another level of care. Assessment documentation profiles will be proposed in future years and as such will not be in scope for the current work.

The PPOC Profile provides a mechanism for capture and electronic exchange of data related to creating and managing individualized patient care 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 for example informed by models of care used in the Clinical Care Classification (CCC) System³, 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 PPOC focuses on the following six components in a clinical document:

1. Assessment
2. Nursing Diagnosis
3. Outcomes Identification

² O'Kane M, Corrigan J, Foote SM, Tunis SR, Isham GJ, Nichols LM, Fisher ES, Ebeler JC, Block JA, Bradley BE, Cassel CK, Ness DL, Tooker J. (2008). *Health Affairs*;27(3):749-58.

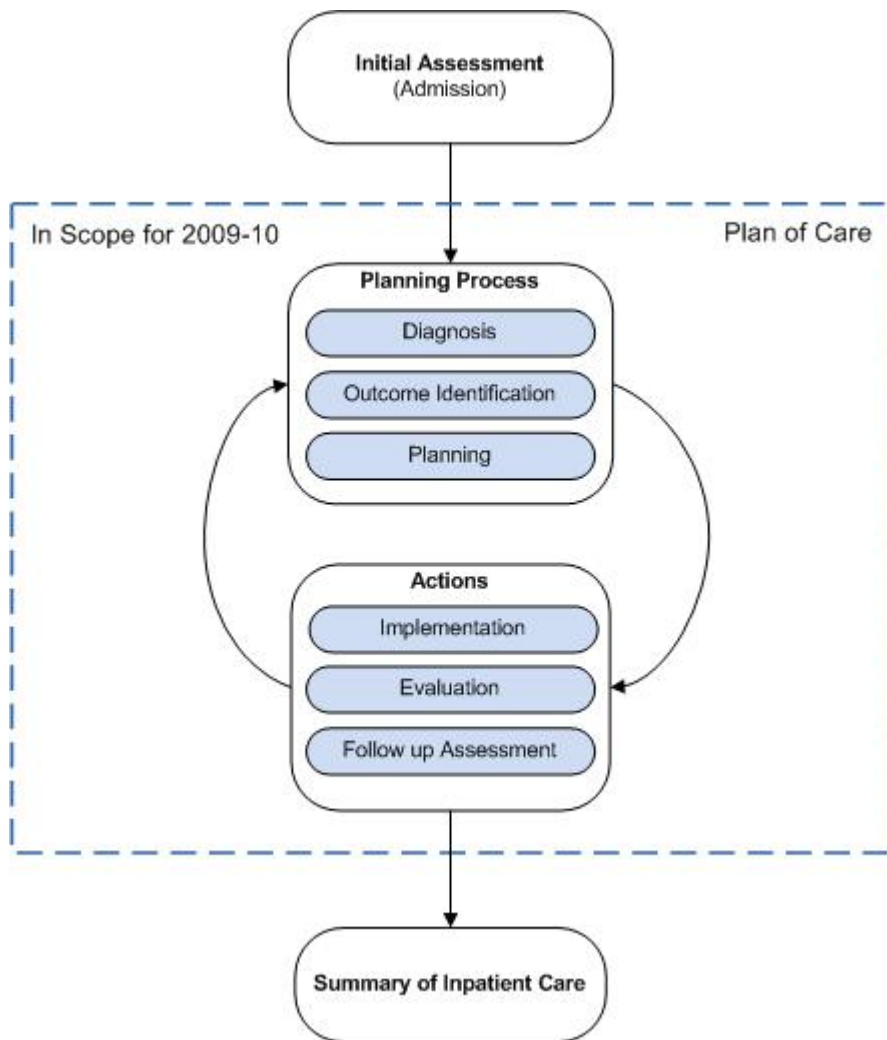
³ Saba, V.K. (2007). *Clinical Care Classification (CCC) System Manual: a Guide to Nursing Documentation*. New York, NY, Springer Publishing

4. Planning
5. Implementation (Interventions)
6. Evaluation

180

185

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 implementing actions to provide care for the patient based on the plan. Evaluation measures the current patient progress against the expected outcomes through subsequent assessments. Evaluations are used to adjust the nursing plan. These components are performed continuously through the care process.



190

Figure X-1. Nursing Process

195 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 PPOC 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 PPOC Profile is able to support coded nursing documentation. This allows healthcare organizations to access data on the complexity of patient conditions and the care performed by professional nurses and other allied professionals to improve the quality of care provided and facilitate continuity of care.

200 Use Case

205 A 70 year old male is admitted to a hospital unit after presenting to the Emergency Department (ED) with productive cough, acute rib pain, increased work of breathing, decreased lung sounds bilaterally, pulse oximetry saturation of 88%, temperature of 39 degrees Celsius (102.2 degrees Fahrenheit), 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.

Upon admission to the unit, the nurse reviews documentation of ED care delivery, clinician orders, labs, xrays, and any other available data. An assessment is completed by the nurse. With assessment and information obtained in ED, the nurse determines issues (nursing diagnosis), expected outcomes, recommended interventions and evaluation criteria. The nurse determines:

210 Issues (nursing diagnoses)

- Respiratory alteration
- Acute pain

Expected outcomes:

- 215
- Maintenance of oxygen saturation at 95% on room air by pulse oximetry when ambulating
 - Pain maintained within the patient's comfort threshold (0-3) on oral medications

Planning:

- Interventions planned, based on research evidence, demonstrated to meet quality outcomes
- Information is reviewed with the patient/advocate for agreement and implemented in the plan of care

220 Implementation of interventions:

- Elevation of head of bed 30 to 45 degrees
- Humidified oxygen by nasal canula at 2 liters to maintain saturation above 92%
- Splinting of chest with pillow to reduce pain with cough

Evaluation:

- 225
- Pulse Oximetry is measured at 95% when walking in hall
 - Pain when coughing is reported by patient to be less than 3 on pain scale with oral medications

230 Further assessments occur with any change of condition or at recommended intervals. Evaluation
 235 criteria is compared to outcomes assessed and changes in the PPOC are made. The patient is the
 240 owner of the plan of care and mutual agreement of change is the norm.

X.1 Actors and Transactions

235 There are two actors in this profile, the Content Creator and the Content Consumer. Content is
 240 generated 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
 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.

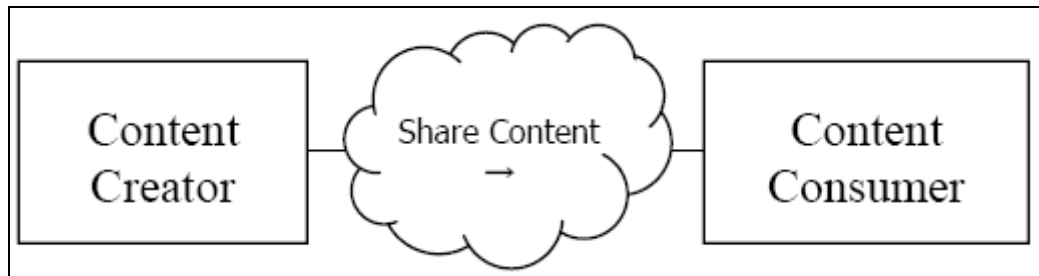


Figure X.1-1. Patient Plan of Care Actors and Transactions

245

Table X.1-1. Patient Plan of Care Options

Actor	Option	Section
Content Consumer	View Option (See Note 1)	PCC TF-2:3.1.1
	Document Import Option (See Note 1)	PCC TF-2:3.1.2
	Section Import Option (See Note 1)	PCC TF-2:3.1.3
	Discrete Data Import Option (See Note 1)	PCC TF-2:3.1.4
Content Creator	None	

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

X.3 Grouping

250 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 healthcare organizations have a coordinated infrastructure that serves the information sharing needs of this community of care. Several mechanisms are supported by IHE profiles:

- 255 • 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.
- 260 • 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.

265 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

270 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)

275 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:

Table X.3.3-1. Minimum Trigger Event Set

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 ⁴ or deletion of the content described within this profile.

⁴ 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.

Trigger Event	Description
Node-Authentication-Failure	Secure node authentication failure is detected.

280

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.

285 **X.3.4 Notification of Document Availability (NAV)**

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.

290

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.

295

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.

300

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 PPOC, defined in section PCC TF-2:6.1.1.Y.

305

While the PPOC focuses on the nursing process, it is a summary document containing the necessary information for the interdisciplinary care planning process.

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 clinical discipline providing that information.

310

315 The purpose of this section is to identify the type of information found in the PPOC. 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

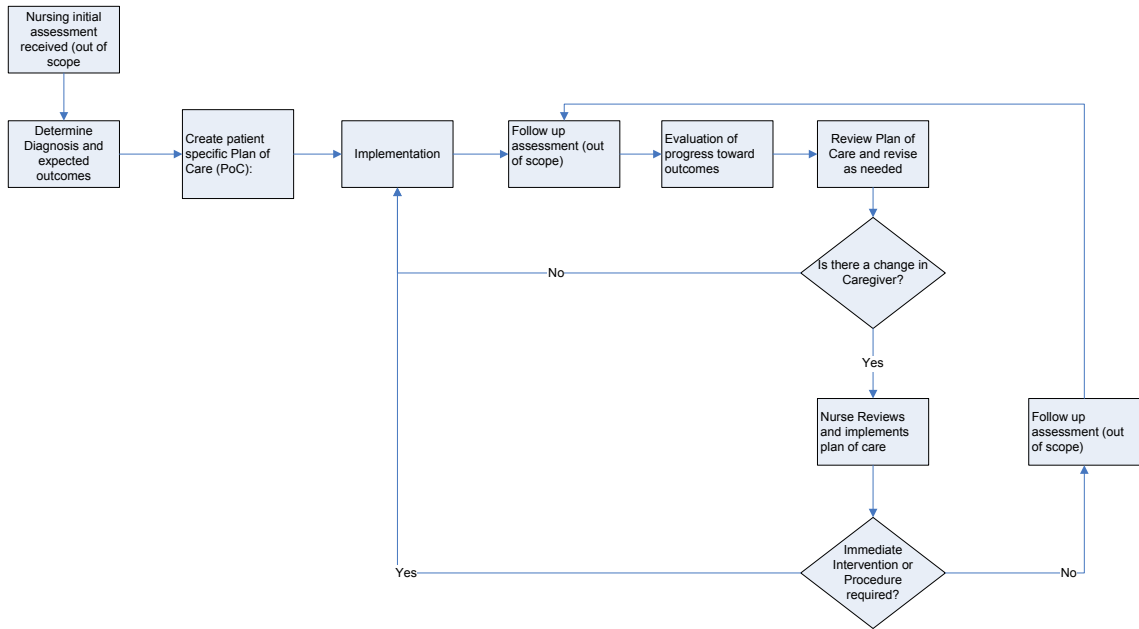


Figure X.5-1. Patient Plan of Care Process Flow

320 This process flow diagram shows the movement of the PPOC 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.

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

330

335

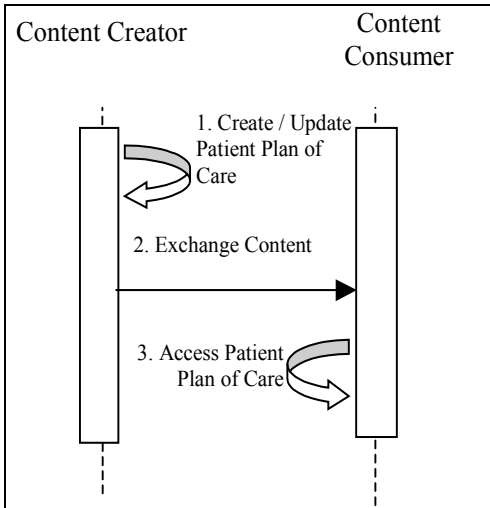


Figure X.5-2. Basic Process Flow in the Patient Plan of Care Profile

340 The following steps show the use of the PPOC 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 clinically relevant data and with the patient develops an individualized plan articulating specific individualized care for that patient based on the Nursing Process. This model includes medical and nursing orders within the electronic health record (EHR) system. The nurse documents the nursing related content for a specific PPOC using coded nursing terminology.
- 345 2. The PPOC is stored within an HIT system.⁵
3. During the inpatient stay, the nurses continually evaluate their actions and review the PPOC frequently to ensure progress and quality care are maintained. The Patient Plan of Care is revised as needed (e.g., in the case of new information or a change in patient condition).
- 350

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

1. When a patient is transferred to another facility the PPOC is reviewed and updated as needed to promote continuity of care.
- 355 2. The updated PPOC is exchanged with the destination facility.
3. The PPOC is reviewed at the destination facility and is updated as needed.

⁵ This step does not always involve and exchange between different HIT systems.

X.6 Patient Plan of Care Security Considerations

360 Reference:

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

365 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 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.

Volume 2 – Transactions and Content

370

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

375 The nursing evaluation and management note contains the information relevant to the six 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 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.
- 380 • Nursing Diagnosis
The problem list section includes any diagnoses based on assessment data and information received from other providers.
- 385 • Expected Outcomes
Identification of individualized expected outcomes for the patient (the goals)
- Planning
390 Planning is the stage in the process to prescribe treatments and interventions to be 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.
- 395 • Evaluation
Evaluation of the effectiveness of the plan is identified at the time of assessment. The nurse documents patient response toward PPOC goal attainment.

In addition to these sections, the PPOC may also include other information relevant to the planning process, such as:

- 400 • Discharge Planning
The PPOC includes notation of anticipated discharge needs and progress towards meeting those needs. This includes patient and family teaching, prescriptions, durable medical equipment, social/medical services etc.

- Orders
405 The PPOC includes a section referencing clinician 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
The PPOC documents the presence or absence of patient allergies.
- History of Past Illness
410 The PPOC includes History of Past Illness relevant to care planning
- Surgical History
The PPOC includes any relevant prior surgical history.
- Advance Directives
415 The PPOC includes information about any relevant advance directives or note their absence.
- Immunizations
The PPOC includes information about the patient’s immunization status (e.g., recent flu shot).
- Family and Social History
420 The PPOC includes information about relevant family and social history pertinent to the individualized care the patient requires.

425 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. 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

430 **6.1.1.Y.3 Data Element Index**

Data Element	LOINC	ANA 2004
Assessment	51848-0 ASSESSMENTS	Assessment
Physical Examination	29545-1 PHYSICAL EXAMINATION	Assessment
Review of Systems	10187-3 REVIEW OF SYSTEMS	Assessment
Coded Functional Status	47420-5 FUNCTIONAL STATUS ASSESSMENT	Assessment

Data Element	LOINC	ANA 2004
Assessment		
Family History	10157-6 HISTORY OF FAMILY MEMBER DISEASES	Assessment
Social History	29762-2 SOCIAL HISTORY	Assessment
History of Past Illness	11348-0 HISTORY OF PAST ILLNESS	Assessment
Surgical History	47519-4 HISTORY OF PROCEDURES	Assessment
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

6.1.1.Y.4 Specification

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

- IHE Patient Care Coordination Volume 2: Final Text
- IHE PCC CDA Content Modules Supplement

435

Data Element Name	Opt	Template ID
Assessments This section should 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 should 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 should 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
Coded Functional Status Assessment This section should be present when any assessments of functional status are performed on the patient.	C	1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1

Data Element Name	Opt	Template ID
Family History This section should be present when there is relevant family history	O	1.3.6.1.4.1.19376.1.5.3.1.3.14
Social History This section should be present when there is relevant 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 addressed by the PPOC.	R	1.3.6.1.4.1.19376.1.5.3.1.3.6
Allergies and Other Adverse Reactions Section This section should be present and record the presence or absence of any allergies.	R	1.3.6.1.4.1.19376.1.5.3.1.3.13
Treatment Plan The treatment plan section contains a description of the planned care and goals.	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 should be present and record the presence or absence of any advance directives.	R	1.3.6.1.4.1.19376.1.5.3.1.3.34
Procedures and Interventions This section should 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 should 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 should 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 should 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 should 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 should be present to record relevant immunization status.	C	1.3.6.1.4.1.19376.1.5.3.1.3.23

R = Required; R2 = Required if data present; O = Optional; C = Conditional

6.1.1.Y.5 Conformance

440 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.

445

```
450 <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' />
455 <confidentialityCode code='N' displayName='Normal'
  codeSystem='2.16.840.1.113883.5.25' codeSystemName='Confidentiality' />
  <languageCode code='en-US' />
  :
  <component><structuredBody>
460   <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>
465
   <component>
     <section>
       <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15' />
       <!-- Conditional Physical Examination Section content -->
470     </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 -->
475     </section>
   </component>
   <component>
     <section>
       <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1' />
       <!-- Conditional Coded Functional Status Assessment Section content -->
480     </section>
   </component>
485
   <component>
     <section>
       <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.14' />
       <!-- Optional Family History Section content -->
490     </section>
   </component>
   <component>
     <section>
       <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.16' />
       <!-- Optional Social History Section content -->
495     </section>
   </component>
500
   <component>
     <section>
       <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.6' />
       <!-- Required Active Problems Section content -->
505     </section>
   </component>
```

```

510 <component>
    <section>
        <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>

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

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

530 <component>
    <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.34' />
        <!-- Required Advance Directives Section content -->
    </section>
535 </component>

    <component>
    <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11' />
540 <!-- Conditional Procedures and Interventions Section content -->
    </section>
</component>

    <component>
    <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.21' />
545 <!-- Conditional Medications Administered Section content -->
    </section>
</component>

550 <component>
    <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6' />
        <!-- Conditional Fluids Administered Section content -->
    </section>
555 </component>

    <component>
    <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.8' />
560 <!-- Conditional History of Past Illness Section Section content -->
    </section>
</component>

565 <component>
    <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.12' />
        <!-- Conditional Coded List of Surgeries Section Section content -->
    </section>

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```
570 </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.23' />
575 <!-- Conditional Immunizations Section Section content -->
      </section>
    </component>

580 </structuredBody></component>
</ClinicalDocument>
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Figure 6.1.1.Y.5-1. Patient Plan of Care Example