

Integrating the Healthcare Enterprise



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**IHE Patient Care Coordination (PCC)
Technical Framework Supplement**

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**Patient Care Plan Content Profile
(PtCP)**

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Trial Implementation

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Foreword

25 This is a supplement to the IHE Patient Care Coordination Technical Framework V9.0. Each supplement undergoes a process of public comment and trial implementation before being incorporated into the volumes of the Technical Frameworks.

This supplement is published on October 4, 2013 for Trial Implementation and may be available for testing at subsequent IHE Connectathons. The supplement may be amended based on the
30 results of testing. Following successful testing it will be incorporated into the Patient Care Coordination Technical Framework. Comments are invited and may be submitted at http://www.ihe.net/PCC_Public_Comments.

This supplement describes changes to the existing technical framework documents.

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

<i>Amend section X.X by the following:</i>
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40 Where the amendment adds text, make the added text **bold underline**. Where the amendment removes text, make the removed text **~~bold strikethrough~~**. When entire new sections are added, introduce with editor’s instructions to “add new text” or similar, which for readability are not bolded or underlined.

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

Information about the IHE Patient Care Coordination domain can be found at: http://www.ihe.net/IHE_Domains.

45 Information about the organization of IHE Technical Frameworks and Supplements and the process used to create them can be found at: http://www.ihe.net/IHE_Process and <http://www.ihe.net/Profiles>.

The current version of the IHE Patient Care Coordination Technical Framework can be found at: http://www.ihe.net/Technical_Frameworks.

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Introduction to this Supplement

- 155 Each health care discipline organizes care for their patients using a structured format (i.e., Care Plan, Plan of Care, and Treatment Plan). The terminology used for the structured format is contextually confusing, but typically synonymous in content. These documents remain within each disciplines domain, but are exchanged with other health care providers when necessary. HL7 and IHE have produced standards for the interchange of care plans or documents that contain care plans. Unfortunately, standards for an interoperable, overarching Care Plan that aligns, supports, and informs person-centric care delivery regardless of setting or service provider is non-existent.
- 160 This profile will produce a model for a dynamic and shared “organizing care plan” which will facilitate virtual consolidation of plans of care and treatment plans without violating the autonomies of each health care discipline’s care plans and planners. It will produce the conceptual Patient Care Plan model that is unified (through cross-pollinated meeting participation) with the HL7 Care Plan Domain Access Model (CP DAM), IHE, and other
- 165 stakeholders. It will contain aspects of the disjointed plan fragments that must be organized for reconciliation. It will support reconciliation of problems, medications and allergies in accordance with IHE RECON profile. In order to complete the profile in a useful time frame, we will produce a “minimalist” first version.

Open Issues and Questions

- 170 None

Closed Issues

1. (Closed 03/21/2013) What is PtCP scope in relationship to Clinical Practice Guidelines?-discussed below
- 175 2. (Closed 4/30/13) Will this solution fit with the IHE Technical Framework work or profiles? Yes see volume 3 and this profile will be referenced for all future IHE profiles.
3. (Closed 7/22/13) As a coordinating framework, IHE does not invite unsolicited updates to the Care Plan fragment from any participant. This may concern some stakeholders and they may petition to have their entire data models placed into this profile or they may be hesitant to participate at all. We intend to use the Public Comment period as an
- 180 opportunity for stakeholders to share their opinions.
4. (Closed 4/30/13) Modeling too deeply on the first version would create costly and unnecessary delays. Implementers need to start building version one solutions in 2013.
5. (Closed 4/30/13) How does PtCP align with HL7 care plan implementation guides? Currently the Implementation Guide is will only be referencing how to implement the C-CDA which will use the CDA Care Plan section, it does not address the deficiencies for
- 185 Goals.

6. (Closed 4/30/13) How does the PtCP align with the C-CDA and IHE content? And what Sections do we want from the IHE content or the C-CDA document? See discussion below about harmonizing IHE templates and C-CDA templates.
- 190 7. (Closed 4/30/13) Do we want a CP template document instead of a CP section similar to CCD? No - see discussion below related to reusing current C-CDA templates as well as current IHE templates and the development of new IHE content requiring new IHE template IDs. See discussion below which shows how the current CDA Care Plan section will be reused in conjunction with new sections proposed by this profile.
- 195 8. (Closed 7/24/13) Within the current C-CDA constructs and IHE constructs there are no opportunity to include Goals in a structured way. There is a need to be able to support interoperability/report patient goals. This provides an opportunity for future work in this area. We've discussed this in the profile.
- 200 9. (Closed 7/24/2013) Because of current transition to universal content, IHE templates and C-CDA templates are included in this guide. At the completion of the profile harmonizing the IHE PCC and C-CDA templates, the referenced C-CDA templates will be removed and the new harmonized templates will be used. ***Until IHE harmonization is complete recommendation in this profile is to use either the list of IHE templates or C-CDA templates.***
- 205 10. (Closed 7/24/13) The current Patient Education Section only includes a required (R) entry for Immunization Education. This section would not be able to be used for this profile unless we change the required (R) optionality to optional (O) or do we consider Patient Education as an Intervention and then Patient Education would become an entry within the Intervention Section. For this profile we can decide which optionality the entries
- 210 should have.
11. (Closed 7/24/13) The IHE Procedures and Interventions template 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 section shall contain a narrative description of the actions performed by a clinician and has a required (R) Procedure entry, LOINC 29544-3 code. This entry provides coded values for procedures performed during the encounter.
- 215 There is not an entry for "Interventions" within the Procedures and Interventions section. This leads to confusion about where to place interventions (e.g., patient education, IV insertions, latex precautions implemented). For clinicians procedures and interventions have different meanings and developers abide by the definitions of the sections and entries for where to place information and the Procedures and Interventions section only addresses "procedures". Also, the title of the Procedures and Interventions section and the Coded List of Surgeries section 1.3.6.1.4.1.19376.1.5.3.1.3.12 which shall include entries for procedures and references to procedure reports when known as described in the Entry Content Modules can make where to place procedural information difficult. The Coded List of Surgeries section also contains a required (R) procedure entry
- 220 1.3.6.1.4.1.19376.1.5.3.1.4.19. Procedures and Surgeries are often interchangeable terms for clinicians meaning the same thing (e.g., a surgical procedure Coronary Artery Bypass Graft, an invasive procedure Coronary Artery Catheterization, a non-invasive
- 225

- 230 echocardiogram). All of these have applicable CPT (Current Procedural Terminology) codes and could be labeled procedures making it confusing about where to place procedures and leaving an empty space for placing interventions within the sections. Deferred to harmonization work completion.
- 235 12. (Closed 7/24/13) PtCP Profile using IHE templates need a section for historical medical devices and equipment. IHE currently has three medical devices section templates. Implanted Medical Device Review Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.46 is a Text only medical device review section which contains a description of the medical devices that are inserted into the patient, whether internal or partially external. Visible Implanted Medical Devices Section 1.3.6.1.4.1.19376.1.5.3.1.1.9.48 describes medical devices apparent on physical exam that have been inserted into the patient, whether internal or partially external. It has an entry which is a problem Observation. Using the following Medical Devices Section Template ID 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.5.
- 240 13. (Closed 7/24/13) Is there a need for two PtCP documents template IDs – one for document using IHE templates and the other for use with CCDAs templates? Will this be needed for conformance testing? Will this be needed until IHE harmonization is complete? OID requests sent to IHE PCC Co-Chair.
- 245 14. (Closed 7/24/13) IHE Template IDs needed for the following: PtCP Profile (Document); Hospital Discharge Instructions Section; Patient Care Plan Section; Reconciled Plan of Care Section; Patient Goals Section; Plan Medical Devices and Equipment Section. OID requests sent to IHE PCC Co-Chair.
- 250 15. (Closed 7/24/13) What are the appropriate LOINC codes to use for all sections and sub-sections that are of ‘Plan of Care’ type? Should LOINC 18776-5 be used for these types of sections/sub-sections? Change Proposal sent to IHE PCC Co-Chair.
- 255 16. (Closed 7/24/13) Use of UV header template ID when available from the IHE harmonization work. Deferred to harmonization work completion.
- 260 17. (Closed 7/24/13) Until harmonization is complete, should PtCP profile utilizing the CCDAs templates inherit from IHE PCC Medical Document for the purposes of content binding and transactions but not for content purposes? Deferred until harmonization work completion.
- 260 18. (Closed 7/24/13) What is the appropriate LOINC code for the Patient Care Plan section? Using the 56447-6 LOINC code.(Closed 7/24/13) Need to check the technical framework to make sure glossary items are not already there. If it is, we need to make sure it does not modify the existing definition. If it does, we need to do a change proposal. The additional glossary terms this profile proposes are not currently present in any of the other IHE Profiles or the IHE Glossary of Terms.
- 265 19. (Closed 4/30/13) As a coordinating framework, the profile could inform the care plan structures of future IHE profiles and mapping to pre-existing IHE profiles such as Patient

Plan of Care (PPOC) will need to be performed. Yes this profile will be referenced for all future IHE profiles.

20. (Closed 07/25/13) Ability to reconcile care plan content provided.

270

General Introduction

275 *Update the following Appendices to the General Introduction as indicated below. Note that these are not appendices to Volume 1.*

Appendix A - Actor Summary Definitions

Add the following actors to the IHE Technical Frameworks General Introduction list of Actors:

280 No new actor definitions.

Appendix B - Transaction Summary Definitions

Add the following transactions to the IHE Technical Frameworks General Introduction list of Transactions:

No new transactions.

285 Glossary

Add the following glossary terms to the IHE Technical Frameworks General Introduction Glossary:

Glossary Term	Definition
Acute Care	Inpatient care designed to treat or cure a disease or injury that has a rapid onset and follows a short course or requires immediate attention in a hospital.
Ambulatory Care	All types of health services that do not require an overnight hospital stay.
Goals	A defined outcome or condition to be achieved in the process of patient care. Goals include patient defined goals (e.g., prioritization of health concerns, interventions, longevity, function, comfort) and clinician specific goals to achieve desired and agreed upon outcomes.
Health Concerns	The issues/current status and likely course identified by the patient or team members that require intervention(s) to achieve the patient's goals of care, any issue of concern to the individual or team member.
Home Care	Professional care (e.g., skilled nursing, physical therapy, speech-language pathology, occupational therapy, medical social work, home health aide) that an individual of any age with an acute or chronic condition, as well as a disability or a terminal illness, receives in the home. The professional will work with the patient and their families to teach them about their condition as well as how to care for themselves or the patient, so that the patient can be independent. A physician or a clinician with prescriptive authority is required to document or verbally communicate an order for the services to be provided.
Inpatient	A patient who is admitted to a hospital or clinic for treatment that requires at least one overnight stay. (Reference: Perinatal Workflow)

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Glossary Term	Definition
Instructions	Information or directions to the patient and other providers including how to care for the individual's condition, what to do at home, when to call for help, any additional appointments, testing, and changes to the medication list or medication instructions, clinical guidelines and a summary of best practice. This is provided as a list of action steps given to a team member or patient to address health concerns.
Interventions	Actions taken to maximize the prospects of achieving the patient's or providers' goals of care, including the removal of barriers to success. Instructions are a subset of instructions.
Long-Term Care	A variety of services that help people, who have a chronic illness or disability, with medical or non-medical care needs and activities of daily living over a specified period of time. Long-term can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Outcome	The status of the patient at one or more points in time in the future, related to the established care plan goals.
Outpatient	A patient not hospitalized >24 hours or housed in an extended care facility, who is being treated in an office, clinic, or other ambulatory care facility (Reference: Perinatal Workflow)
Patient Care Plan	The synthesis and reconciliation of the multiple Plans of Care produced by each provider to address specific health concerns of the patient. See below Plan of Care definition.
Plan of Care	A concept some clinicians use to focus on discrete problems, the specific interventions to address the problem, and achieve a certain goal related to the problem.
Post-Acute Care	The recuperative or rehabilitative care needed to recover from a serious injury or illness.
Team Member	Parties who manage and/or provide care or service as specified and agreed to in the care plan, including clinicians, other paid and informal caregivers, and the patient.
Treatment Plan	A concept developed by a provider in collaboration with the individual to address an individual's health concern under the purview of a single provider.

Volume 1 – Profiles

290 **Copyright Licenses**

Add the following to the IHE Technical Frameworks General Introduction Copyright section:

Not applicable

Domain-specific additions

None

295

Add Section X

X Patient Care Plan (PtCP)

300 Patient Care Plan is a content profile that defines a centralized patient care plan that will meet the needs of many stakeholders (providers and patients) and provide a method to reconcile and consolidate the many disparate care plans that can be attached to a patient. It provides the beginning of a framework for a centralized patient care plan.

X.1 Actors/Transactions

305 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 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 in the section on Content Bindings with XDS, XDM and XDR in PCC TF-2:4.1.



Figure X.1-1: Actor Diagram

320 X.1.1 Requirements of Actors

X.1.2. Content Modules

Table X.1.2-1 lists the content module(s) defined in the PtCP Profile. To claim support with this profile, an actor shall support all required content modules (labeled “R”) and may support optional content modules (labeled “O”).

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Table X.1.2-1: PtCP Summary Content Modules

PtCP Datum	Content Modules	Optionality	PCC Template ID	CCDA Template Id
Demographics	Header Modules	R	See Note 1	N/A
Problems	Active Problem Section	R	1.3.6.1.4.1.19376.1.5.3.1.3.6	2.16.840.1.113883.10.2.0.22.2.5.1

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PtCP Datum	Content Modules	Optionality	PCC Template ID	CCDA Template Id
Health Concern	Health Concern Section	R	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5	2.16.840.1.113883.10.20.22.2.58
Health Status Evaluations/Outcomes	Health Status Evaluations/Outcomes Section	R	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9	2.16.840.1.113883.10.20.22.2.61
Allergies	Allergies Section	R	1.3.6.1.4.1.19376.1.5.3.1.3.13	2.16.840.1.113883.10.20.22.2.6.1
Medications	Medications Section	R	1.3.6.1.4.1.19376.1.5.3.1.3.19	2.16.840.1.113883.10.20.22.2.1.1
Patient Care Plan	Patient Care Plan Section	R	1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1	1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1
Results	Results Section	R	1.3.6.1.4.1.19376.1.5.3.1.3.28	2.16.840.1.113883.10.20.22.2.3.1
Discharge Medications	Hospital Discharge Medications Section	R2	1.3.6.1.4.1.19376.1.5.3.1.3.22	2.16.840.1.113883.10.20.22.2.11.1
Discharge Diet	Discharge Diet section	R2	1.3.6.1.4.1.19376.1.5.3.1.3.33	1.3.6.1.4.1.19376.1.5.3.1.3.33
Administered Medications	Medications Administered Section	O	1.3.6.1.4.1.19376.1.5.3.1.3.21	2.16.840.1.113883.10.20.22.2.38
Discharge Diagnosis	Discharge Diagnosis Section	R2	1.3.6.1.4.1.19376.1.5.3.1.3.7	2.16.840.1.113883.10.20.22.2.24
Procedures	Procedures Section	R2	1.3.6.1.4.1.19376.1.5.3.1.3.7	2.16.840.1.113883.10.20.22.2.7.1
Discharge Studies Summary	Hospital Discharge Studies Summary Section	O	1.3.6.1.4.1.19376.1.5.3.1.3.30	2.16.840.1.113883.10.20.22.2.16
Advance Directives	Advance Directives Section	R2	1.3.6.1.4.1.19376.1.5.3.1.3.35	2.16.840.1.113883.10.20.22.2.21.1
Historical Encounters	Encounters Histories Section	O	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.3	2.16.840.1.113883.10.20.22.2.22.1
Family History	Family History Section	O	1.3.6.1.4.1.19376.1.5.3.1.3.15	2.16.840.1.113883.10.20.22.2.15
Functional Status	Functional Status Section	R2	1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1	2.16.840.1.113883.10.20.22.2.14
Assessment	Assessment Section	R2	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.4	2.16.840.1.113883.10.20.22.2.8
Immunizations	Immunizations Section	R2	1.3.6.1.4.1.19376.1.5.3.1.3.23	2.16.840.1.113883.10.20.22.2.2.1
Medical Equipment	Medical Equipment Section	O	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.5	2.16.840.1.113883.10.20.22.2.23
Payers	Payers Section	O	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7	2.16.840.1.113883.10.20.22.2.18

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PtCP Datum	Content Modules	Optionality	PCC Template ID	CCDA Template Id
Social History	Social History Section	O	1.3.6.1.4.1.19376.1.5.3.1.3.16.1	2.16.840.1.113883.10.2.0.22.2.17
Vital Signs	Vital Signs Section	O	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2	2.16.840.1.113883.10.2.0.22.2.4.1
History of Past Illness	History of Past Illness Section	O	1.3.6.1.4.1.19376.1.5.3.1.3.8	2.16.840.1.113883.10.2.0.22.2.20
Review of System	Review of System Section	O	1.3.6.1.4.1.19376.1.5.3.1.3.18	1.3.6.1.4.1.19376.1.5.3.1.3.18
Physical Exam	Physical Exam Section	O	1.3.6.1.4.1.19376.1.5.3.1.1.9.15	2.16.840.1.113883.10.2.0.2.10
Discharge Physical Exam	Hospital Discharge Physical Exam Section	O	1.3.6.1.4.1.19376.1.5.3.1.3.26	1.3.6.1.4.1.19376.1.5.3.1.3.26
Instructions	Instructions Section	R2	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11	2.16.840.1.113883.10.2.0.22.2.45
Discharge Instructions	Hospital Discharge Instructions Section	R2	1.3.6.1.4.1.19376.1.5.3.1.1.26.1.3	2.16.840.1.113883.10.2.0.22.2.41

Note 1:PtCP is a medical summary and inherits all header constraints from Medical Summaries. 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. CCDA US Realm header elements can be used when the CCDA flavor of templates are implemented.

330

X.2 Options

Options that may be selected for this Content Profile are listed in the table X.2-1 along with the Actors to which they apply. Dependencies between options when applicable are specified in notes.

335

Table X.2-1: PtCP Summary Options

Actor	Option Name	Reference
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	No options defined	

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

X.3 Groupings

This section not applicable

X.4 Overview

- 340 The management of medically complex and/or functionally impaired individuals requires all different types of ‘plans’ and ‘instructions’. The following depicts this concept:



Figure X.4-1: Structure of Patient Care Plan

- 345 A Care plan can contain multiple plans of care which are comprised of treatment plans and instructions. The following further depicts this concept:



Figure X.4-2: Contents of Patient Care Plan

- 350 A Care plan can contain multiple plans of care which are comprised of treatment plans and instructions from various types of care providers including updates from the patient/caregiver. The following further depicts this concept:

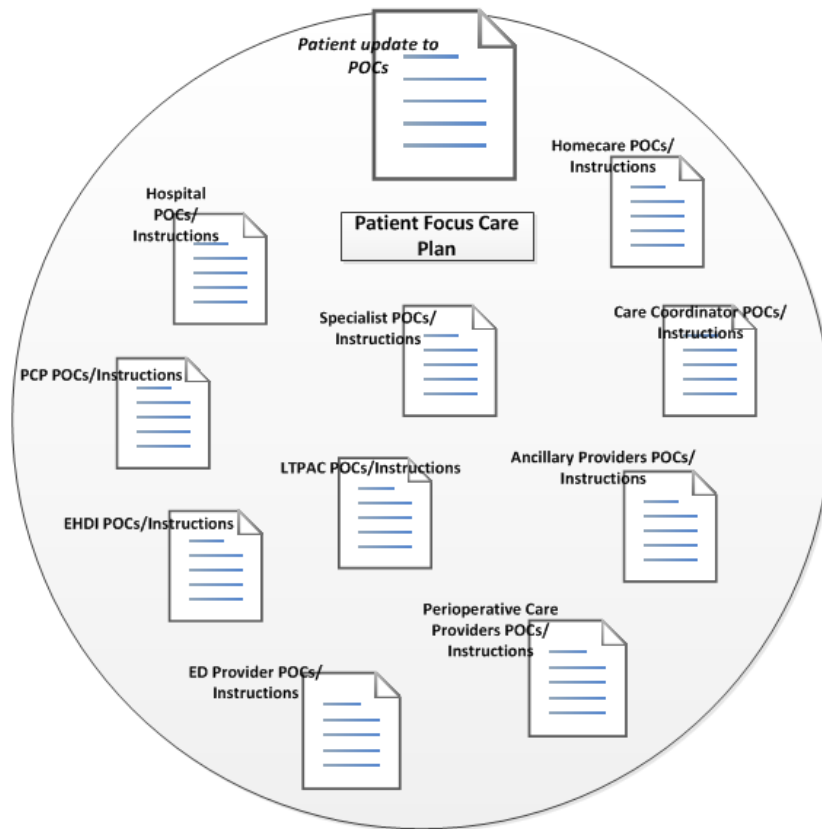


Figure X.4-3: Multiple Contributions to Patient Care Plan

355

The PtCP is a content profile that could be used to drive clinical workflow. The numbers of health care service delivery encounters required by individuals, as well as the failure to deliver and coordinate needed services are significant sources of frustration and errors and are drivers of health care expenditures. According to claims data reported for US Medicare beneficiaries in 2003-2004, 19.6% of re-hospitalizations occurred 30 days after discharge. This translated into \$17.4 billion dollars in hospital payments from Medicare in 2004.¹ Providing person-centered care is particularly important for medically-complex and/or functionally impaired individuals given the complexity, range, and on-going and evolving nature of their health status and the services needed. Effective, collaborative partnerships between service providers and individuals are necessary to ensure that individuals have the ability to participate in planning their care and that their wants, needs, and preferences are respected in health care decision making.

365

¹ Coleman, MD, MPH, Eric A. "Preparing Patients and Caregivers to Participate in Care Delivered Across Settings: The Care Transitions Intervention." *Journal of the American Geriatric Society* 52, (2004): 1817-1825.

370 The ability to target appropriate services and to coordinate care over time, across multiple clinicians and sites of service, with the engagement of the individual (i.e. longitudinal coordination of care) is essential to alleviating fragmented, duplicative and costly care for these medically-complex and/or functionally impaired persons. The Patient Care Plan profile will support one overarching interdisciplinary plan of care where all disciplines that care for the patient are able to communicate their plan of care, treatment plan, problems, interventions and goals/outcomes, for the patient.

375 A key component of clinical workflow is the ability to reconcile clinical data. Reconciliation of electronic clinical information from multiple data sources is a difficult task. It involves managing lists of clinical information that are often larger than most people can keep in working memory. This profile supports the reconciliation of information contained in Health Information Systems and Exchanges. It can be used to provide automation of reconciliation tasks and clinical
380 workflows. This profile includes information that can be used to enable reconciliation of active problems, medications, and allergies (see IHE PCC Reconciliation of Diagnoses, Allergies and Medications [RECON] Profile) data. This can be used to assist healthcare providers to automate complex reconciliation tasks. Furthermore, patient care is sometimes based on care guidelines. Care guidelines typically results in protocols that are used to produce clinical workflow. The
385 workflow drives what occurs or does not occur. This information is captured in a care plan and can subsequently be reported on by providing a link to quality measures and outcomes. For example, care guidelines for diabetic patients include an annual foot exam. The annual foot exam is included in a diabetes care protocol. Subsequently, a referral or order for diabetes foot exam to be performed becomes a component of the clinical workflow for a diabetic patient. In order to
390 satisfy the workflow, the annual foot exam becomes a plan item in the patient care plan that is tracked until the exam is performed. The outcome for the performing of the annual foot exam intervention can then be tracked for quality purposes.

The PtCP profile will address many of the needs not met in the Patient Plan of Care (PPOC) profile due to being nursing focused. The PtCP will provide:

- 395
- A centralized Patient Care Plan that meets the needs of many stakeholders (providers and patients);
 - A method to consolidate the many Plans of Care that can be attached to a patient;
 - A framework for the centralized Patient Care Plan.

400 The PtCP profile will utilize IHE workflow profiles such as XDS, XDW, ORL (Order/Referral Linking), RECON (Reconciliation) and content profiles such as Medical Summary based documents and CCD for the exchange of each disciplines patient care document and their data elements.

405 The PtCP profile document will contain data elements representing a collection of clinical data that documents a Care Plan with the various plans of care created by one or more clinicians caring for the patient. Further, it provides the patient-centered holistic view which results from the reconciliation of the various Plans of Care. It also provides a description of the progress

towards completing expectations for care including actions completed in fulfillment of proposals, goals, and order requests for monitoring, tracking, or improving the condition of the patient.

410 The PtCP Document will be composed of several sections including a new Patient Care Plan
 Section. The new Patient Care Plan section will contain subsections including Plans of Care, a
 Reconciled Plan of Care, Patient Goals, Reconciled Goals, Interventions, and Reconciled
 Interventions sections. The purpose of the Reconciled Plan of Care is to compile the data
 elements of the various Plans of Care. The Patient Goals subsection describes the patient’s
 415 progress towards expectations for care and the Reconciled Goals subsection will contain
 reconcile goals that have been completed and goals in progress. The Interventions subsection
 will contain entries that display a holistic view of interventions and procedures (e.g., patient
 education, intravenous insertion) provided for patient care and the Reconciled Interventions
 subsection results from the reconciliation of all the various Intervention sections. Other sections
 420 in the PtCP document will be used to provide a retrospective view of care provided to the patient
 and the patient response to care. See example below.

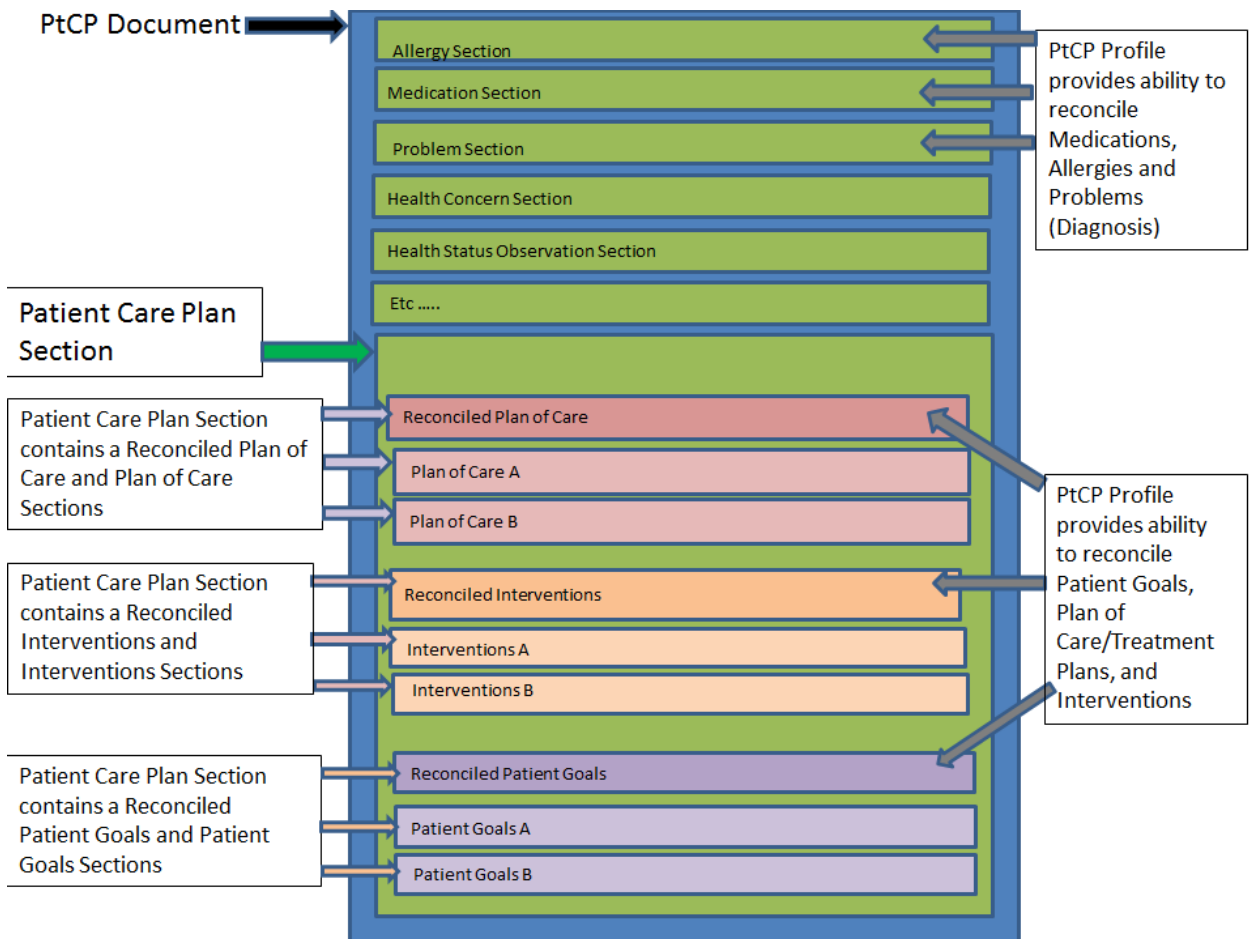


Figure X.4-4: Patient Care Plan Document

X.4.1 Concepts

- 425 A Patient receives care in a care setting. In order to provide care for the patient, a plan is needed (Care Plan). An assessment process and a planning process are conducted.
1. Provider(s) create an action plan for the patient.
 2. The patient Care Plan will *contain multiple* plans of care to deal with varying health concerns. *Goals* are identified in order to determine if the plans of care needs are met.
 - 430 3. Provider(s) create plans of care for each health concern. For example:
 - a. Diabetic ketoacidosis plan of care include the following. Instructions are also embedded in the plans of care.
 - 435 i. Treatment plan for high glucose levels.
 - ii. Treatment plan for abnormal lab results (plan for frequency of lab results and what should be done for abnormal results).
 - iii. ...
 - b. Nursing plan of care may include getting the patient and family ready for the next level of care. Instructions are also embedded in the plans of care.
 - 440 c. Social service’s plan of care includes assisting the patient and family in identifying resources for healthcare financial needs. Instructions are also embedded.
 - d. Physical Therapy plan of care to evaluate and prevent complications related to immobility.

445 The various plans of care are implemented and goals are met. The patient is ready to transition to the next level of care. A summary of the care provided with plan and instructions for the next level of Care is generated and shared. A transient plan may change when another provider plan begins or changes.

450 The summary of care might deal with only those health concerns that the patient had during that episode of care. However, since “the” care plan is shared among participants, *the goals and plans of continuing relevance are adjusted and retained along with the patient input* (see figure X.4-1). The process repeats for the duration of time that the patient interacts with the health care system. This is demonstrated in the supporting use cases.

The supporting use cases below describe the transitioning of a patient’s care across several settings. At each transition, a shared care plan (the PtCP) is affected.

- 455
- Use Case #1: EHDI – Demonstrates the ability to share plans of care so that follow-up care between providers is supported.
 - Use Case #2: Provider to Provider (Collaborative Care) – Demonstrates the ability to share plans of care so that collaborative care is supported.
 - 460 • Use Case #3: Ambulatory Care to Acute Care – Demonstrates the ability to share plans of care so that transitioning between care-settings is supported.

- Use Case #4: Acute Care to Ambulatory Care – Demonstrates the ability to share plans of care so that transitioning between care-settings is supported.
- Use Case #5: Homecare to Ambulatory Care Provider – Demonstrates the ability to share plans of care so that continuing care is supported.
- 465 • Use Case #6: Acute Care to Long Term Post-Acute Care – Demonstrates the ability to share plans of care so that transitioning between care-settings is supported.
- Use Case #7: Emergency Department to Acute Care (Include Surgery) - Demonstrates the ability to share plans of care so that collaborative care is supported within and across care settings.

470 X.4.2. Use Cases

The following use case actors depict functional users. These use case actors are used in the various PtCP profile use cases.

Use Case Actors	Example of Functional Users
PHR-IS	Patient Medical Decision Maker (Legal Guardian (parent, foster parent), Durable Power of Medical Attorney (DPOA))
EHRIS	Health Care Settings (i.e., hospital, home care, ambulatory health care facilities, hospice, laboratory, treatment facilities, managed care organizations) Health Care Providers (i.e., primary care physician (PCP), specialist, pharmacist, nurse, nurse practitioner (NP) or advanced practice nursing providers (APNs), radiologist, podiatrist, respiratory and physical therapist, physician assistants (PA), dietician, dentist, chiropractor, speech pathologist, audiologist, technicians, emergency medical service provider, etc.) Care Coordinator
Public Health-IS (e.g., EHDI-IS)	Health Care Agency (i.e., Public Health Department)

475 X.4.2.1 Use Case #1: EHDI

Early Hearing Detection and Intervention (EHDI) -

Early detection, documentation of and intervention for hearing loss in infants born with congenital and delayed onset hearing issues ensures effective care for all children, especially those with special needs. To provide better care, pediatric providers need to share screening results as well as a Care Plan for each infant which includes next steps such as who requires additional screening or direct referral for audiologic diagnosis; who requires ongoing developmentally appropriate hearing screening because of risk factors for delayed or progressive hearing loss; and who should be referred to early intervention services. Use of a Care Plan such as the Early Hearing Care Plan (EHCP) enables multiple care providers engaged in the early care and intervention for hearing to better manage the ongoing care plan actions. This would support communication between participants of care to reduce the likelihood of procedural failures at

birthing facilities, primary care settings, public health EHDI programs, and families with children with hearing loss thus advancing public health’s ability to assure that all newborns receive recommended care.

490 **X.4.2.1.1 EHDI Use Case Description**

Early Hearing Detection and Intervention (EHDI) -

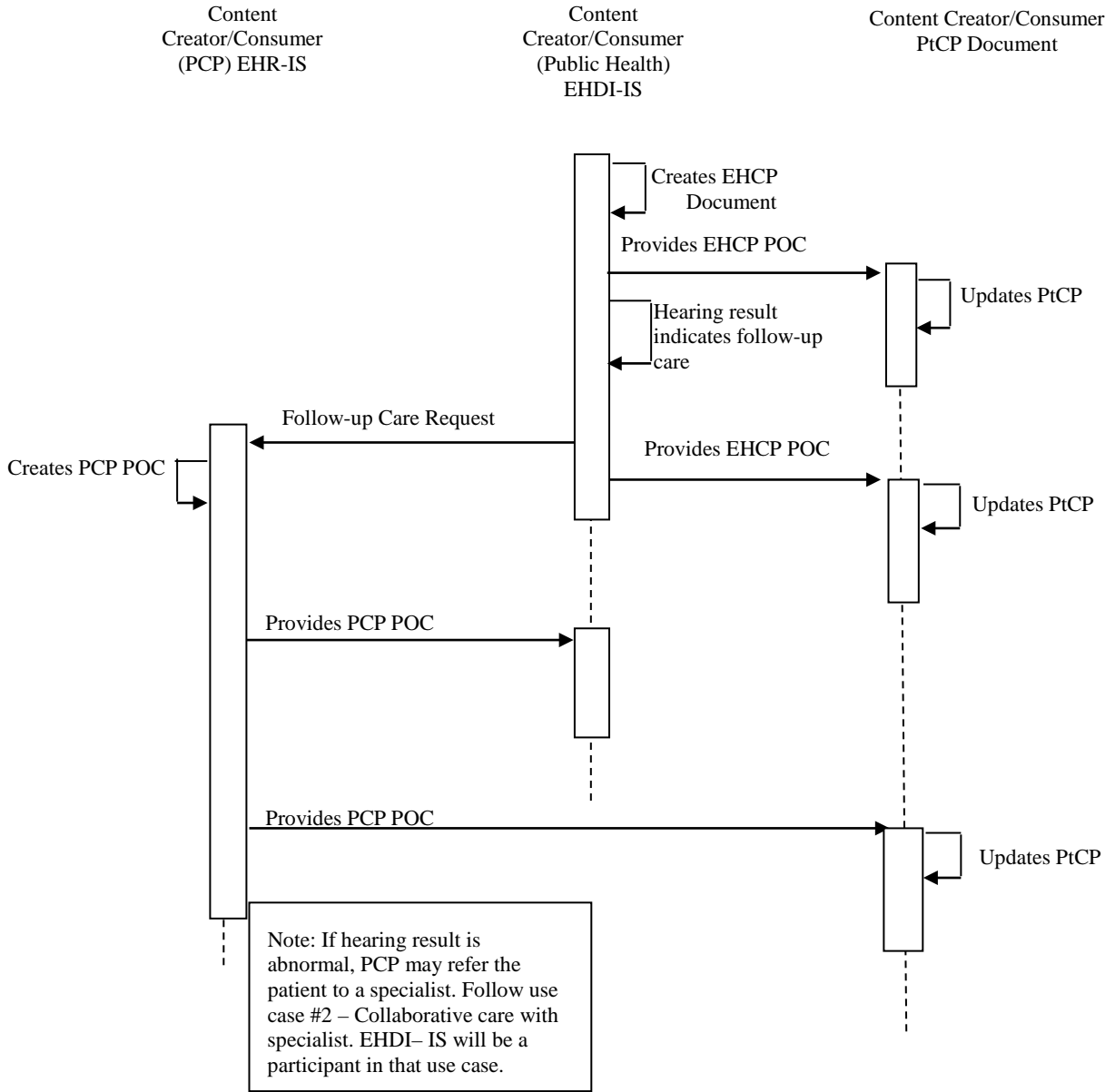
Newborn Hearing Screening (NHS) is initiated based on public health (PH) guidelines. At birth, the birthing center provider initiates the NHS so that the screening is performed. The screening result is submitted to the Public Health Early Hearing and Detection Intervention (EHDI) program which calculates the NHS outcomes. The NHS outcome is presented in the EHCP including follow-up activity. The typical collaboration flow is as follows:

- a. L&D EHR sends birth notification to the State EHDI program’s Information System (EHDI-IS)
- b. EHDI-IS sends request for NB hearing screening to L&D EHR
- 500 c. Upon discharge Hospital EHR notifies the EHDI-IS of demographic and birth details as well as hearing screening results
- d. EHDI-IS compiles the Early Hearing Care Plan (EHCP) and shares it with the PtCP service
- 505 e. If hearing screening results indicate a referral should be done, EHDI-IS initiates a referral request to the baby’s care providers (PCP or Specialist) and sends referral order to the PTCP service
- f. PCP or Specialist performs consultation and sends consultation results to the PtCP service. This information is also needed by the EHDI-IS

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520 **X.4.2.1.2 EHDI Process Flow**



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Figure X.4.2.1.2-1: EHDI Basic Process Flow in PtCP Profile

X.4.2.2 Use Case #2: Provider to Provider (Collaborative Care)

560 Provider to provider collaborative care is central to care provided to a patient. This use case demonstrates how a patient care plan is used and contributed to inform care providers of the care the patient receives.

X.4.2.2.1 Provider to Provider (Consultant, Allied Health Care Provider) Use Case Description

565 X.4.2.2.1.1 Primary Care Provider

Pre-Condition: Patient Mr. Bob Individual attends his primary care physician (PCP) clinic because he has been feeling generally unwell in the past 7-8 months. His recent blood test results reveal abnormal glucose challenge test profile.

570 **Encounter:** After reviewing Mr. Individual’s medical history, presenting complaints and the oral glucose tolerance test results, Dr. Patricia Primary concluded that the patient suffers from Type II Diabetes Mellitus (Type II DM).

Dr. Primary accessed Mr. Individual’s medical record, records the clinical assessment findings and the diagnosis.

575 Dr. Primary discusses with Mr. Individual the identified problems, potential risks, goals, management strategies and intended outcomes. After ensuring that these are understood by the patient, Dr. Primary begins to draw up a customized chronic condition (Type II DM) plan of care based on a standardized multi-disciplinary Type II DM Plan of Care adopted for use by her practice. Agreed goals and scheduled activities specific for the care of Mr. Individual were entered into the new plan of care.

580 Dr. Primary also discusses with the patient the importance of good nutrition and medication management and exercises in achieving good control of the disease, as well as the criticality of good skin/foot care and eye care to prevent complications. Scheduling of consultations with diabetic educator, dietitian, exercise physiologist, community pharmacist, optometrist, and podiatrist (specialists and allied health care providers) is discussed and agreed to by the patient.

585 Dr. Primary also notices signs and symptoms of mood changes in the patient after the diagnosis is made. She recommends that the patient may benefit from seeing a clinical psychologist to which the patient also agrees.

590 Dr. Primary generates a set of referrals to these specialists, allied health care providers. The referrals contain information about the patient’s medical history including the recent diagnosis of Type II diabetes, reasons for referral, requested services and supporting clinical information such as any relevant clinical assessment findings including test results. A copy of the plan of care agreed to by the patient is attached to the referral.

Post Condition: Once the plan of care is completed, it is committed to the patient’s medical record. The patient is offered a copy of the care plan.

595 A number of referrals in the form of notification/request for services together with a copy of integrated plan of care are made available to the relevant health care providers.

X.4.2.2.1.2 Specialists, Allied Health Care Providers

600 **Pre-Condition:** Individual specialist and allied health care provider have received a referral with copy of plan of care from Dr. Patricia Primary. The allied health care provider has accepted the referral and scheduled a first visit with the patient – Mr. Bob Individual

Encounter: Mr. Bob Individual is registered at the allied health care provider’s reception. Any additional or new information provided by the patient is recorded in the health care record system operated by the allied health provider clinic.

605 During the first consultation, the specialists and allied health care provider reviews the referral and plan of care sent by Dr. Primary. During subsequent consultation, specialists and the allied health care providers review the patient’s health care record and most recent plan of care of the patient kept in the allied health care provider care record system.

610 At each consultation, the specialists and allied health care provider review the patient’s health record, assesses the patient, checks the progress and any risks of non-adherence (compliance) and complications, and discusses the outcomes of the management strategies and/or risks, Any difficulties in following the management strategies or activities by the patient are discussed and new/revised goals and timing as well as new intervention and self-care activities are discussed and agreed to by the patient. The new/changed activities are scheduled and target dates agreed upon.

615 The specialists and allied health care providers update the clinical notes and the care plan with the assessment details, and any changes to the management plan including new advices to the patient. The date of next visit is also determined.

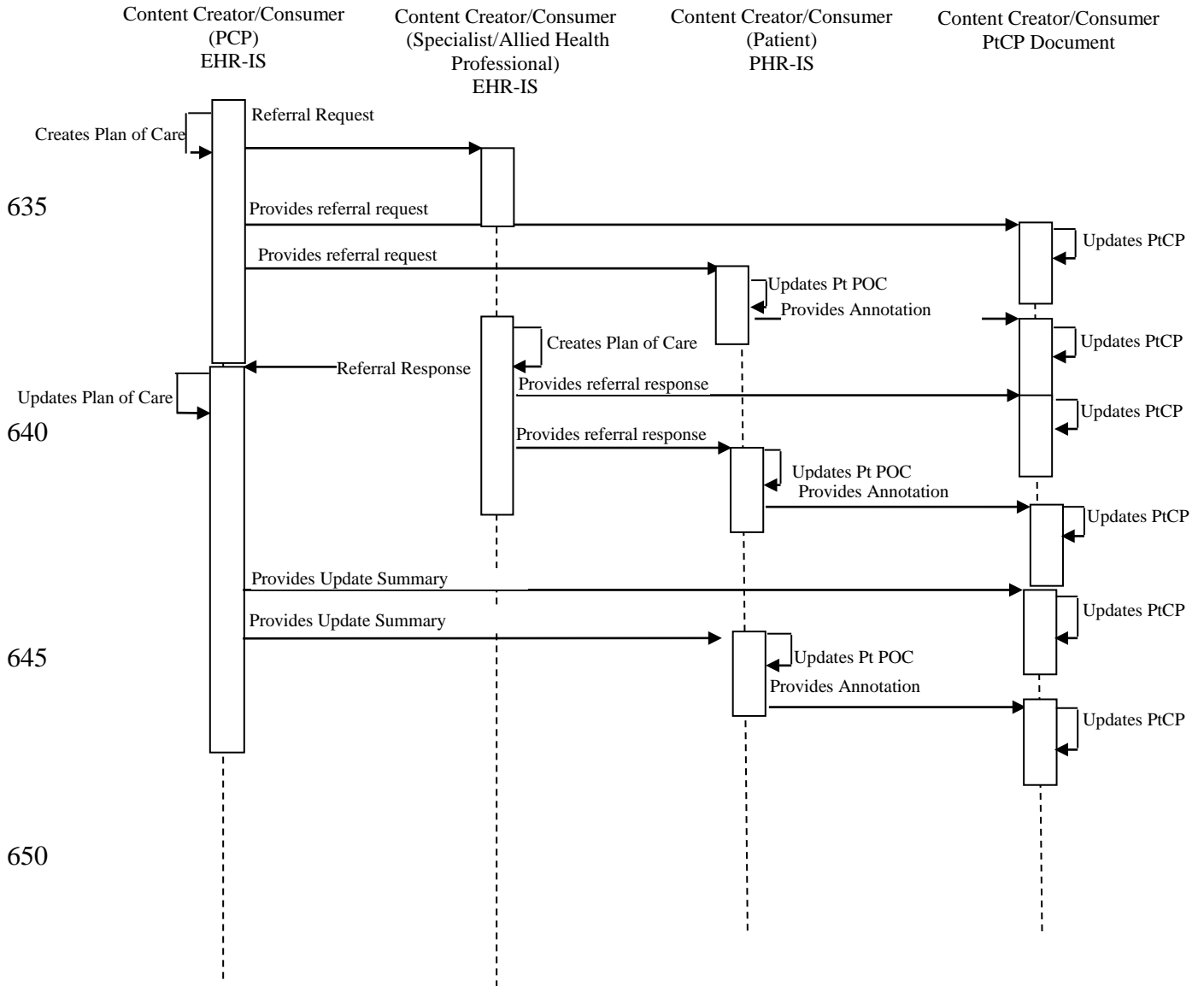
Post Condition: An updated specialist and allied health domain specific plan of care complete with action items and target dates are completed with patient agreement.

620 The patient is given a copy of the new/updated care plan at the end of each specialist and allied health consultation. Summary care plan and progress note is made available to primary care provider and to other care providers.

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X.4.2.2.2 Provider to Provider (Collaborative Care) Process Flow

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655 **Figure X.4.2.2.2-1: Provider to Provider (Collaborative Care) Basic Process Flow in PTCP Profile**

X.4.2.3 Use Case #3: Ambulatory to Acute

X.4.2.3.1 Ambulatory to Acute Use Case Description

660 **Pre-Condition:** Mr. Bob Individual develops a severe episode of influenza with broncho-pneumonia and very high blood glucose level as complications. He suffers from increasing shortness of breath on a Saturday afternoon.

Encounter: Mr. Individual presents himself at the Emergency Department of his local hospital as Dr. Primary's clinic is closed over the weekend.

665 Mr. Individual is admitted to the hospital and placed under the care of the physicians from the general medicine clinical unit. During the hospitalization, the patient is given a course of IV antibiotics, insulin injections to stabilize the blood glucose level. Patient was assessed by hospital attending physician, Dr. Allen, as medically fit for discharge after four days of inpatient care. Dr. Allen reconciles the medications to continue, outlines follow up information and discusses post discharge care with the patient. He recommends the patient to consider receiving
670 influenza immunization before the next influenza session and updates this as recommendation to Dr. Primary in the patient's discharge plan of care.

Planning for discharge is initiated by the physician and nurse assigned to care for the patient soon after admission as per hospital discharge planning protocol. The discharge plan of care is finalized on the day of discharge and a discharge summary is generated.

675 **Post Condition:** The patient's discharge plan of care is completed. This plan may include information on changes in medications, management recommendations to the patient's primary care provider and the patient, and any health care services that are requested or scheduled for the patient.

The patient is given a copy of the discharge summary that includes the discharge plan of care.

680 A discharge summary with an overview of the discharge plan is sent to the patient's primary care provider, Dr. Primary with recommendation for pre-influenza season immunization.

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690 **X.4.2.3.2 Ambulatory to Acute Care Process Flow**

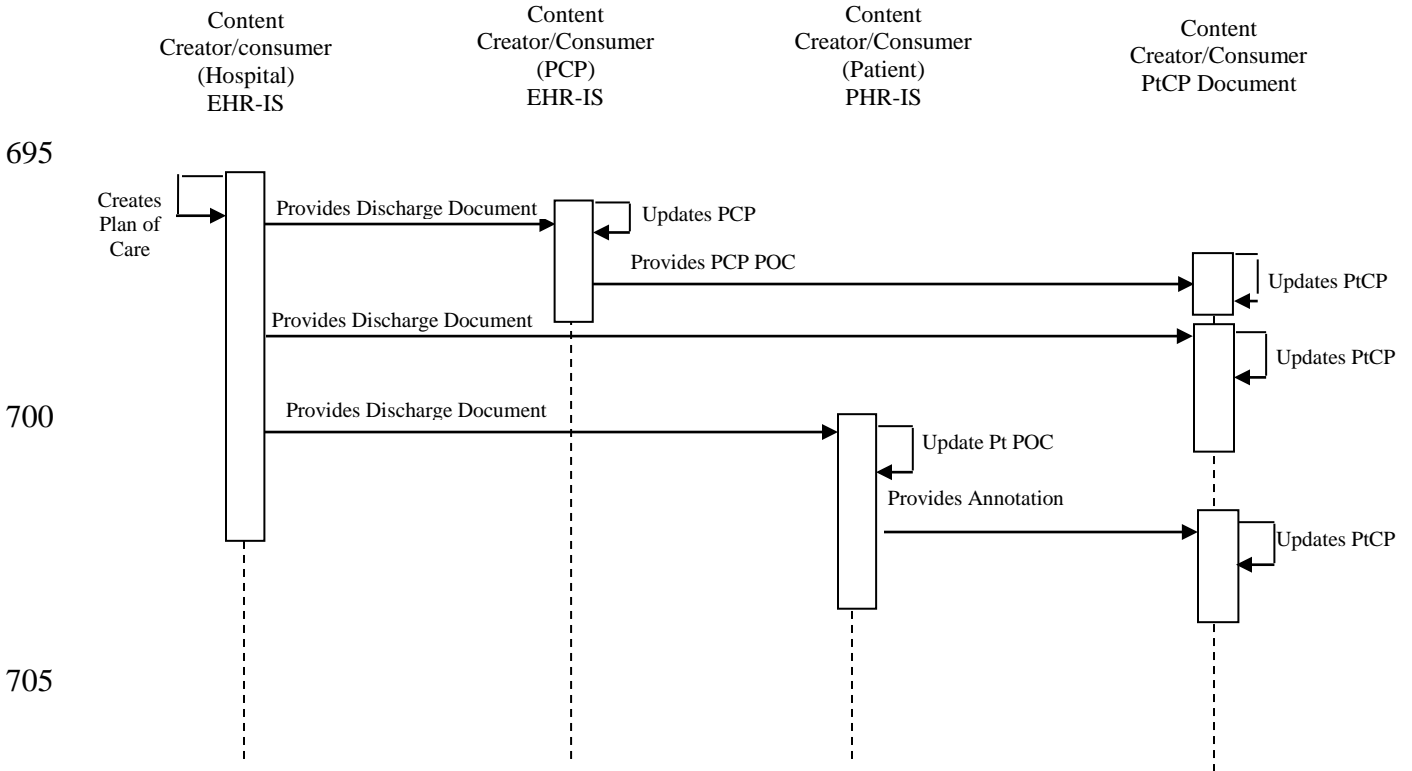


Figure X.4.2.3.2-1: Ambulatory to Acute Care Basic Process Flow in PtCP Profile

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X.4.2.4 Use Case #4: Acute Care to Post-Acute Ambulatory Care

Provider to Provider Transitions of Care focus on the sharing of patient information between multi-disciplinary teams of Providers across acute and post-acute care sites to support care coordination, management, and service delivery by ensuring that needed clinical information is received (when authorized) by the multiple Providers involved in a patient’s care and supports safe and effective transitions in care from one care environment to another.

715

X.4.2.4.1 Acute Care to Post-Acute Ambulatory Care Use Case Description

Pre-Condition: Mr. Bob Individual is a mildly obese 70 year old male with Type II Diabetes who becomes short of breath when walking up a flight of stairs. For the past week he has had a non-productive cough with shortness of breath when walking from his bed to his easy chair in his living room. He has not felt like cooking or eating, but continues to take his daily Glyburide

720

tablet as instructed by Dr. Primary his primary care physician. He has also felt feverish, lightheaded, and clammy for two days. This morning his daughter found him in his living room chair obtunded with shallow breathing.

725 **Encounter:** Mr. Bob Individual presented to Mercy Medical Center’s Emergency Department due to his primary care physician’s clinic being closed on weekends. He was diagnosed with a severe episode of influenza with broncho-pneumonia and very high blood glucose level as complications.

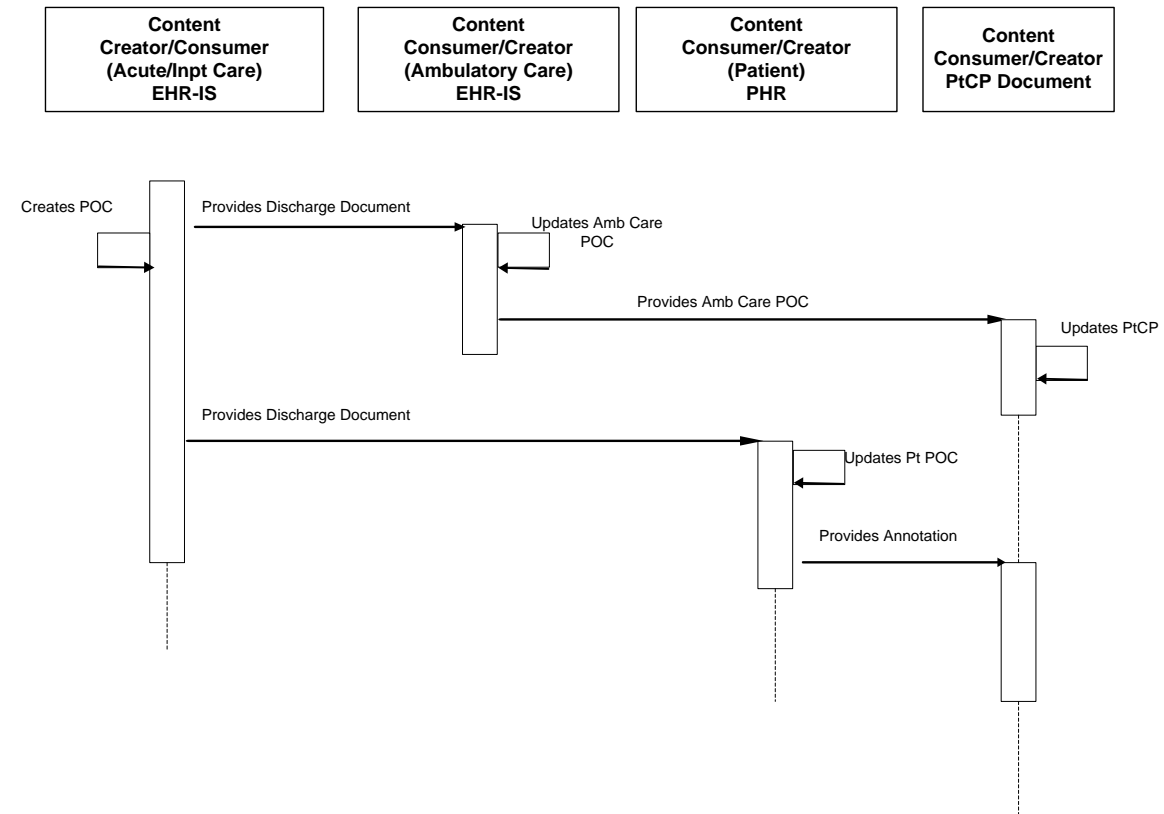
730 Mr. Individual is admitted to the hospital’s medical unit and placed under the care of the physicians from the general medicine clinical unit. During his hospitalization, the patient is given a course of IV antibiotics and placed on an insulin drip the first few days to stabilize his blood glucose level. Mr. Individual was assessed daily by hospital attending physician, Dr. Allen, who determined Mr. Individual was medically fit for discharge after four days of inpatient care. Dr. Allen reconciles the medications to continue after hospital discharge, outlines follow up
735 information and discusses post discharge care with the patient and his daughter. He recommends to the patient to consider receiving annual influenza immunizations before the next influenza season and updates this as a recommendation to Dr. Primary in the patient’s discharge plan of care.

740 Planning for discharge is initiated by the inpatient physician, Dr. Allen, and nurse assigned to care for Mr. Individual as per hospital discharge planning protocol. The discharge plan of care is finalized on the day of discharge and a discharge summary is generated for the patient and sent to Dr. Primary.

745 Post Condition: Mr. Bob Individual is taken home from the hospital by his daughter. His daughter reviews the discharge plan with her father, Mr. Individual, and reviews the medication he is supposed to take daily for seven days and the new insulin instructions regarding his twice daily glucose checks for seven days. Mr. Individual’s daughter makes a follow-up appointment for her father with Dr. Primary seven days from today. She prepares meals for him for the week and will check in with him via the phone daily and in-person in two days.

750 Dr. Primary receives a copy of the discharge plan Dr. Allen and the nurse sent from the hospital. He incorporates the recommendation for an influenza vaccination into his Plan of Care for Mr. Individual and will discuss this with Mr. Individual at his follow-up appointment in seven days.

X.4.2.4.2 Acute Care to Post-Acute Ambulatory Care Process Flow



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Figure X.4.2.4.2-1: Basic Process Flow in PtCP Profile

X.4.2.5 Use Case #5: Home Care to Provider

The focus is on the sharing of electronic clinical information between Home Health Agencies and the Physician signing orders for the patient. This represents a frequent data interchange between HHA and Physician, including the signing and authorization of the plan, in a circumstance where the patient lives at home.

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X.4.2.5.1 Home Care to Provider Use Case Description

Pre-Condition: Mr. Bob is discharged from the hospital with a stage3 decubitus ulcer and orders for home health services to evaluate and treat.

Encounter: Initial home health assessment includes a request to the provider of record (Dr. Primary) for approval of the initial home health plan of care. The plan of care includes an order for daily wet-to-dry dressing changes due a slow healing wound. Home health assessment and plan of care is documented in the home health system. A copy of the assessment and plan of care as well as the initial order request transaction is sent to Dr. Primary EMR. Approval of the plan of care is sent from Dr. Primary to the home health agency. Lillian’s incision worsens. The home

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775 health nurse sends an updated order request to increase dressing changes from once daily to twice daily. She includes an image of the wound and scanned nursing notes describing the incision as well as wound measurements. Dr. Woods receives the information and decides to order wound vac therapy instead of wet to dry dressing changes. The discontinued order for the wet-to-dry dressing change and the new order for wound vac therapy are forwarded to the home health nursing system. The nurse agrees with Dr. Primary's change in the patient treatment plan.

780 **Post Condition:** The wound improves and the nurse informs Dr. Primary. Dr. Primary discontinued wound vac therapy and wet-dry dressing changes are resumed. The nurse instructs Mr. Bob's daughter how to perform the dressing changes and discontinue home health services when Dr. Bob's daughter becomes proficient with the wound care.

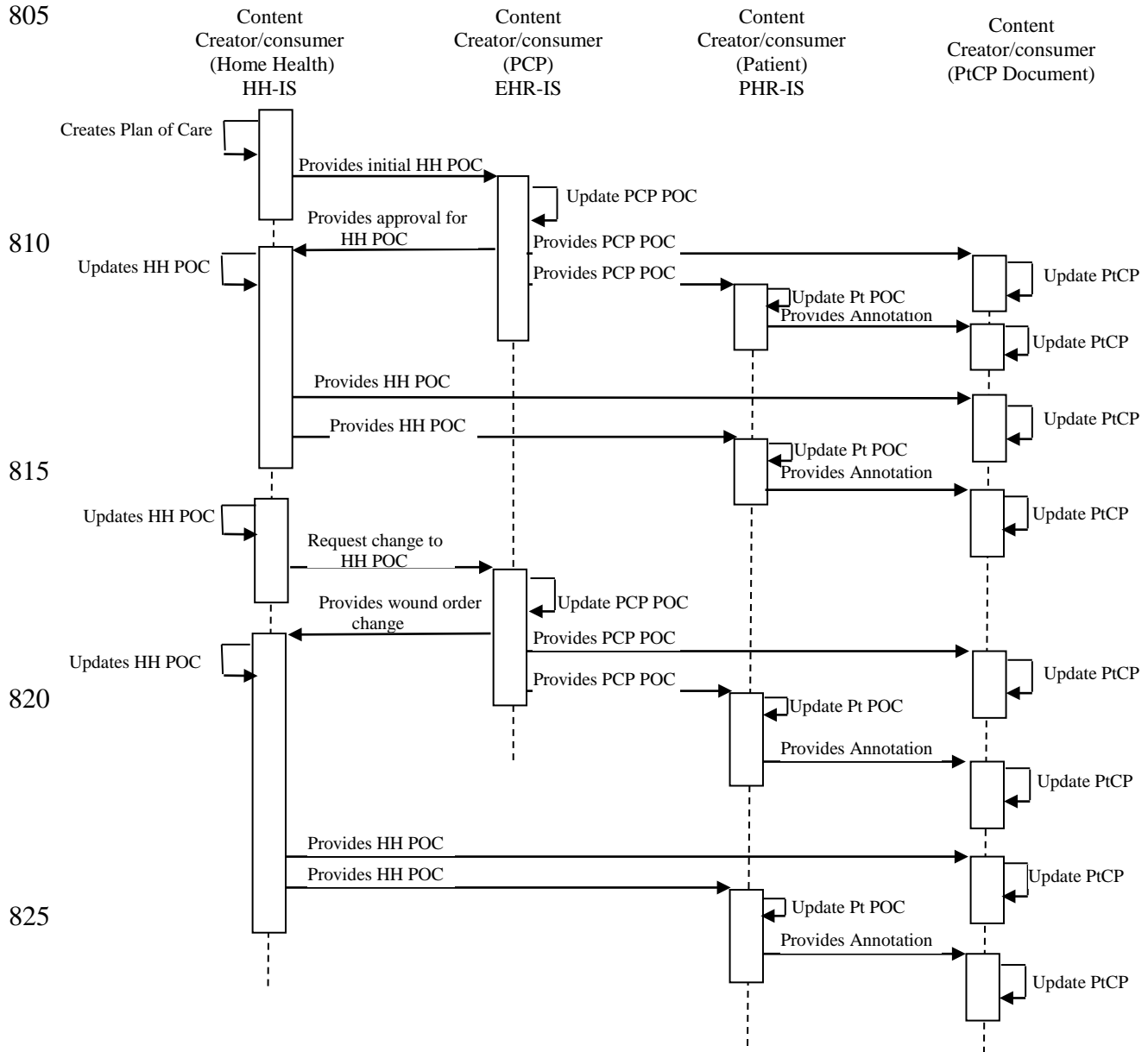
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X.4.2.5.2 Home Care to Ambulatory Provider Process Flow



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Figure X.4.2.5.2-1: Use Case #5 Basic Process Flow in PtCP Profile

X.4.2.6 Use Case #6: Acute to Long Term Post-Acute Care (LTPAC)

835 The focus is on the sharing of electronic clinical information from Acute Care Hospitals and LTPAC Providers to their patients, including the data interchange required to support the needs of a patient during transitions of care, and/or to keep the patient/consumer/ delegate (e.g., family member) informed of the patient’s status. In this scenario, the patient has the ability to access and incorporate their available clinical information into their PHR.

840 X.4.2.6.1 Acute to Long Term Post-Acute Care (LTPAC) Use Case Description

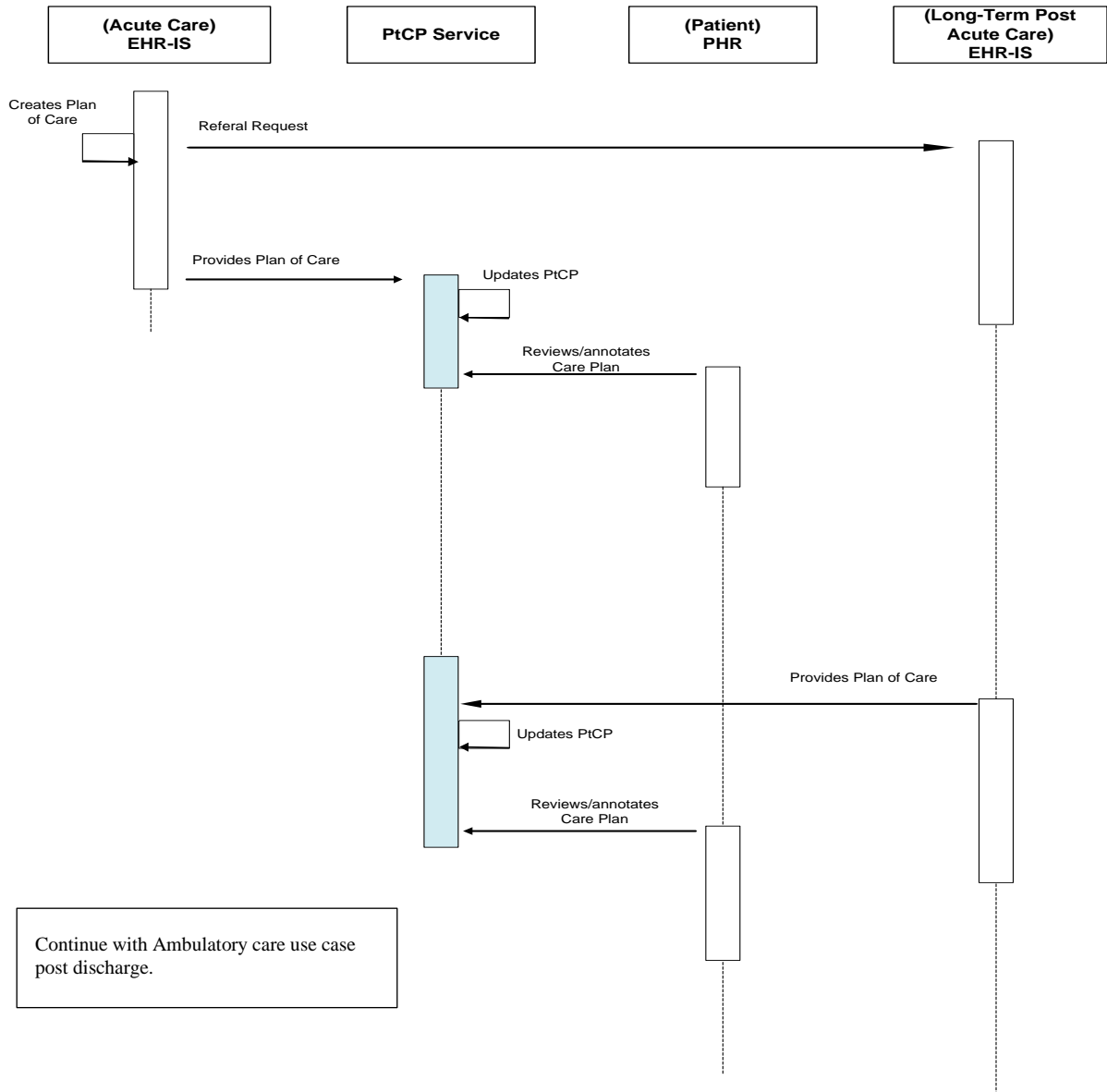
Pre-Condition: Mr. Bob Individual is a diabetic who takes daily insulin and has high blood pressure controlled with his daily diet. He has had a cough for a week and has become increasingly confused and fatigued. He has not eaten dinner for the past two days. He usually eats dinner when his daughter visits every day on the way home from work. His daughter has
845 been out of town for work and she hasn’t visited him for three days. She attempted to call several times during the day, but her father did not answer the phone. Becoming increasingly worried she telephoned a neighbor to check on him. When the neighbor entered the house she found Mr. Individual slumped over in his living room chair. An ambulance was called.

Encounter: Mr. Individual was admitted to the hospital’s medical unit and placed under the care
850 of the physicians from the general medicine unit. During his hospitalization, he is given a course of IV antibiotics for his pneumonia and placed on an insulin drip to stabilize his high blood glucose level. Mr. Individual was assessed daily by the hospital’s medical attending physician, Dr. Allen, who determined Mr. Individual would be medically fit for discharge in four days if his glucose level was stable and converted back to his daily insulin injections and if his course of IV
855 antibiotics improved his pneumonia. During the hospital stay Mr. Individual becomes increasingly confused, combative, and continues to have difficulty breathing even though his pneumonia is resolving. After several tests he is diagnosed with early onset dementia and early onset chronic obstructive pulmonary disease. He will not be able to care for himself alone upon discharge.

860 Planning for discharge is initiated by Dr. Allen, the inpatient physician, and the nurse assigned to care for Mr. Individual as per the hospital’s discharge planning protocol. His pneumonia is resolved as expected, but with his new diagnosis’ he will require twenty-four hour post-acute care in a long term care setting that can accommodate Mr. Individual’s dementia. On the day of discharge, a discharge summary is generated for the patient, the long term care setting, and Dr.
865 Primary, Mr. Individual’s primary care physician.

Post Condition: Mr. Individual is transitioned to the LTPAC setting of his and his daughter’s choice. The LTPAC physician, Dr. Living, reviews a copy of the discharge summary he received from Dr. Allen, the physician from the acute care setting. An initial assessment is performed by Dr. Living and the RN care manager Lucy. Dr. Living and RN Lucy develop a Plan of Care for
870 Mr. Individual that incorporates some of Dr. Allen’s acute care orders and other treatments for Mr. Individual’s new diagnoses. The Plan of Care is reviewed with Mr. Individual and his daughter and placed into action.

X.4.2.6.2 Acute to Long Term Post-Acute Care (LTPAC) Process Flow



875 **Figure X.4.2.6.2-1: Use Case #6 Acute to Long Term Post-Acute Care Process Flow in PtCP Profile**

X.4.2.7 Use Case #7: ED to Acute Care – include Surgery

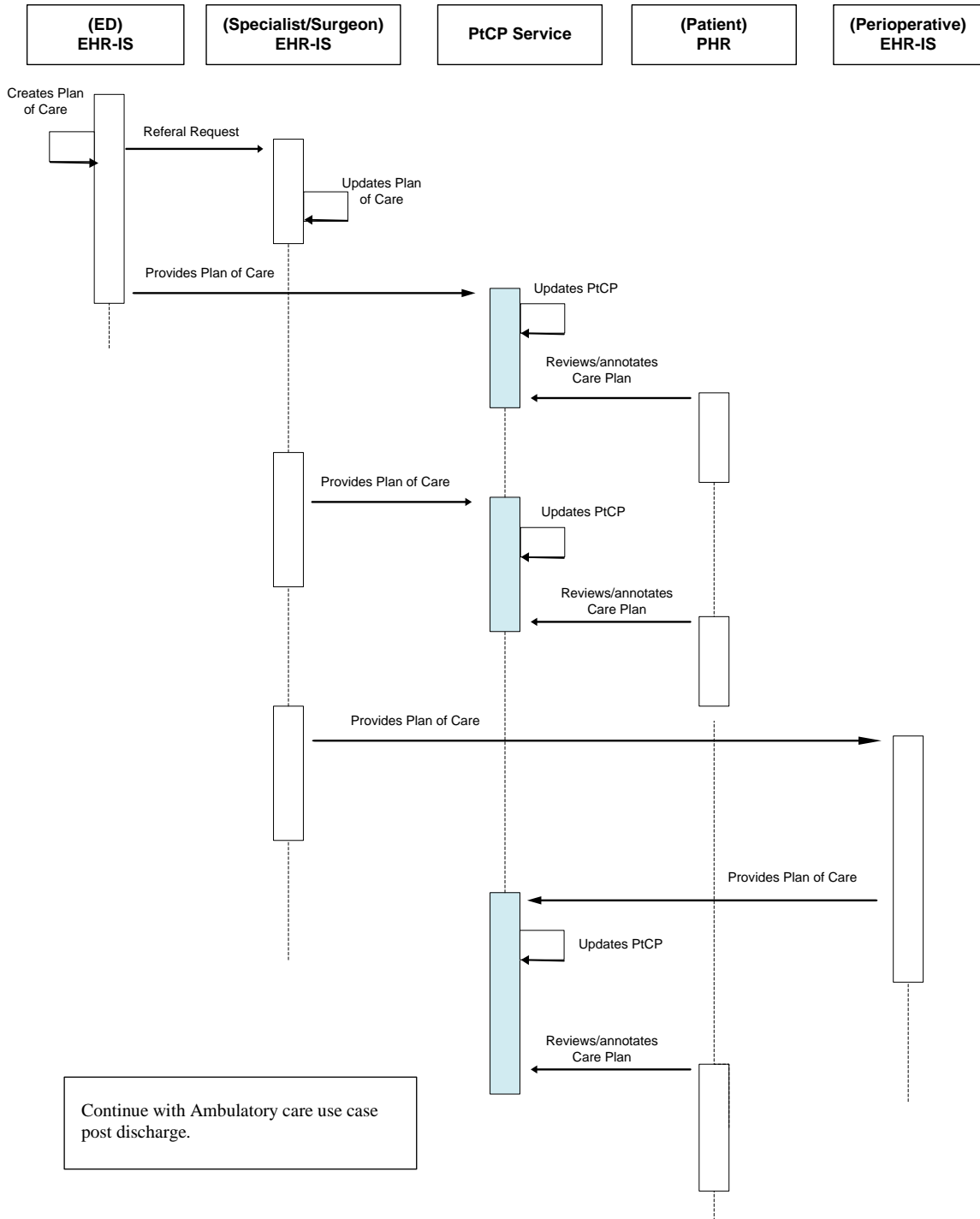
880 The focus is on the sharing of electronic clinical information from a department within the Acute Care Hospital to other providers in other departments within the Acute Care Hospital. This includes providers to their patients, including the data interchange required to support the needs

of a patient during transitions of care, and/or to keep the patient/consumer/ delegate (e.g., family member) informed of the patient's status.

X.4.2.7.1 ED to Acute Care – include Surgery Use Case Description

- 885 **Pre-Condition:** Mr. Bob Individual is mildly obese, has mild hypertension, and diabetes mellitus. After eating a huge Christmas dinner with his family he starts to help clear the table, but he begins to have severe indigestion with a stabbing pain in the middle of his chest. He feels better after sitting down and resting.
- 890 **Encounter:** Mr. Individual and his family arrive at Mercy Medical Center Emergency Department. His pain is now a 9 on a 1-10 pain scale and only slightly relieved with rest. He feels light headed and the pain radiates down his left arm. Upon completing the patient's history and physical the pain is now radiating to his jaw. He is given 80mg Aspirin po, an IV 18 gauge catheter of NS .9% is started in his right hand, labs are drawn, and a 12 Lead EKG is performed which shows mild ST elevation. The emergency department physician contacts the cardiologist specialist who then contacts the cardiac surgeon. The cardiac surgeon determines Mr. Individual needs a cardiac catheterization to properly diagnose his cardiac condition and discusses this with Mr. Individual and his family. Mr. Individual and his family consent to the catheterization and understand the possibility of having to have cardiac surgery. The cardiac surgeon notifies the operating room nurse of the Plan of Care for Mr. Individual and the procedure/surgical suite is prepared according to the plan. Mr. Individual is sent to a hybrid OR for a cardiac catheterization which reveals a 5 vessel myocardium arterial block. A 5 vessel coronary artery by-pass graft (CABG) is performed using his right leg saphenous vein for the vessel repair. After surgery he is sent to the Cardiac Intensive Care Unit (CICU) with an endotracheal tube, 2 chest tubes, an external pacemaker with wires attached, and a Foley catheter. He stays in the CICU for 2 days where he is provided care by the cardiac surgeon, the cardiologist, and the CICU nurses. He is then transitioned to a Cardiac Step-down Unit where he will be discharged home with his wife of 35 years for follow-up care at an outpatient cardiac rehabilitation center. All the care providers within the different care areas need access to the patient's clinical information in order to provide safe, quality care.
- 910 **Post Condition:** Mr. Individual is at home and going to cardiac rehab three times per week. He is getting stronger, but continues to have difficulty sleeping. He has follow-up appointments with his cardiac surgeon and his primary care physician. The primary care physician and the cardiac surgeon receive a copy of Mr. Individual's progress at rehab from his rehab team.

X.4.2.7.2 ED to Acute Care – include Surgery Process Flow



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Figure X.4.2.7.2-1: Use Case #7: ED to Acute Care – include Surgery Process Flow

X.5 Security Considerations

Not applicable

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Appendices

None

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Volume 2 – Transactions

No new transactions to add.

Volume 3 – Content Modules

935 **5 Namespaces and Vocabularies**

Add to section 5 Namespaces and Vocabularies

None

Add to section 5.1.1 IHE Format Codes

940

Profile	Format Code	Media Type	Template ID
Patient Care Plan (PtCP)	urn:ihe:pcc:ptcp:2013	Text/xml	1.3.6.1.4.1.19376.1.5 .3.1.1.26.1 (Using IHE Templates) OR 1.3.6.1.4.1.19376.1.5 .3.1.1.27.1 (Using CCDA Templates)

Add to section 5.1.2 IHE ActCode Vocabulary

None

945 *Add to section 5.1.3 IHE RoleCode Vocabulary*

None

6 Content Modules

950 6.3.1 CDA Document Content Modules

<i>Add to section 6.3.1.D Document Content Modules</i>
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6.3.1.D Patient Care Plan (PtCP) Document Content Module

955 The Patient Care Plan (PtCP) content profile represents the synthesized data that is produced as a result of multiple plans of care produced by each provider to address specific health concerns of the patient. The PtCP is a Medical Summary and inherits all header constraints from Medical Summary. It also uses CDA templates where needed.

6.3.1.D.1 Format Code

The XSDDocumentEntry format code for this content is **urn:ihe:pcc:ptcp:2013**

960 6.3.1.D.2 Parent Template

965 This document is a specialization of the IHE PCC Medical Document template (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1) and if there are reconciled items within this document then the document shall include the Reconciliation Content template ID 1.3.6.1.4.1.19376.1.5.3.1.1.24.1 and if included will also contain sections with the Reconciliation Act (6.3.4.D) template (templateId: 1.3.6.1.4.1.19376.1.5.3.1.1.24.3.1)

6.3.1.D.3 Referenced Standards

All standards which are reference in this document are listed below with their common abbreviation, full title, and link to the standard.

970 **Table 6.3.1.D.3-1: PtCP Document Profile - Referenced Standards**

Abbreviation	Title	URL
CDAR2	HL7 Clinical Document Architecture (CDA Release 2)	http://www.hl7.org/implement/standards/cda.cfm
LOINC	Logical Observation Identifiers, Names and Codes	http://loinc.org/
SNOMED	Systemized Nomenclature for Medicine	http://www.ihtsdo.org/snomed-ct/
CCDA	HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, Release 1.1 - US Realm	http://www.hl7.org/implement/standards/product_brief.cfm?product_id=258
CCDA	HL7 Implementation Guide: S&I Framework Transitions of Care Companion Guide to Consolidated-CDA for Meaningful Use Stage 2, Release 1	http://www.hl7.org/ctl.cfm?action=ballots.participantdetailbydocument&ballot_voter_id=8652&ballot_id=1179&ballot_cycle_id=531

Abbreviation	Title	URL
CCDA	HL7 Implementation Guides for CDA Release 2: Consolidated CDA Templates for Clinical Notes, DSTU Release 2 - US Realm	http://www.hl7.org/ctl.cfm?action=ballots.participantdetailbydocument&ballot_voter_id=8652&ballot_id=1196&ballot_cycle_id=531
RECON	IHE Patient Care Coordination (PCC) Technical Framework Supplement: Reconciliation of Diagnoses, Allergies and Medications	http://ihe.net/Technical_Framework/upload/IHE_PCC_Suppl_Reconciliation_Rev1-1_TI_2011-09-09.pdf

6.3.1.D.4 Data Element Requirement Mappings to CDA

NA

6.3.1.D.5 PtCP Document Content Module Specification

975 This section specifies the header, section, and entry content modules which comprise the PtCP Document Content Module, using the Template ID as the key identifier.

Sections that are used according to the definitions in other specifications are identified with the relevant specification document. Additional constraints on vocabulary value sets, not specifically constrained within the section template, are also identified.

980

Table 6.3.1.D.5-1 PtCP Document IHE Content Module Specification

Template Name	<u>PtCP DOCUMENT</u>				
Template ID	<OID/UID> 1.3.6.1.4.1.19376.1.5.3.1.1.26.1				
Parent Template	IHE PCC MEDICAL DOCUMENT TEMPLATE (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1) Reconciliation Content template ID 1.3.6.1.4.1.19376.1.5.3.1.1.24.1 Note: This template ID should be used in documents that contain entries that have been reconciled.				
General Description	THE PATIENT CARE PLAN (PtCP) CONTENT PROFILE REPRESENTS THE SYNTHESIZED DATA THAT IS PRODUCED AS A RESULT OF MULTIPLE PLANS OF CARE PRODUCED BY EACH PROVIDER TO ADDRESS SPECIFIC HEALTH CONCERNS OF THE PATIENT.				
Document Code	SHALL be Code xxxxx-x, Code System, "Value Set name"> LOINC < Will utilize the same LOINC code as CCDA Care Plan document when available.				
Opt and Card	Condition	Header Element or Section Name	PCC Template ID	Specification Document	Vocabulary Constraint
Header Elements					
R[1..1]	(Note 1)	Demographics	Header Modules	See Note 2	NA
Sections					

IHE Patient Care Coordination Technical Framework Supplement – Patient Care Plan Content Profile (PtCP)

Template Name	<u>PtCP DOCUMENT</u>				
Template ID	<OID/UID> 1.3.6.1.4.1.19376.1.5.3.1.1.26.1				
Parent Template	IHE PCC MEDICAL DOCUMENT TEMPLATE (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1) Reconciliation Content template ID 1.3.6.1.4.1.19376.1.5.3.1.1.24.1 Note: This template ID should be used in documents that contain entries that have been reconciled.				
General Description	THE PATIENT CARE PLAN (PtCP) CONTENT PROFILE REPRESENTS THE SYNTHESIZED DATA THAT IS PRODUCED AS A RESULT OF MULTIPLE PLANS OF CARE PRODUCED BY EACH PROVIDER TO ADDRESS SPECIFIC HEALTH CONCERNS OF THE PATIENT.				
Document Code	SHALL be Code xxxxx-x, Code System, “Value Set name”> LOINC < Will utilize the same LOINC code as CCDA Care Plan document when available.				
Opt and Card	Condition	Header Element or Section Name	PCC Template ID	Specification Document	Vocabulary Constraint
R[1..1]	(Note 1)	Allergies Section	1.3.6.1.4.1.19376.1.5.3.1.3.13	PCC Template See PCC TF Vol2 6.3.3.2.11 Allergies and Other Adverse Reactions Section	
R[1..1]	(Note 1)	Medications Section	1.3.6.1.4.1.19376.1.5.3.1.3.19	PCC Template See PCC TF Vol2 6.3.3.3.1 Medications Section	
R2[1..1]	(Note 1)	Hospital Discharge Medications Section	1.3.6.1.4.1.19376.1.5.3.1.3.22	PCC Template See PCC TF Vol2 6.3.3.3.4 Hospital Discharge Medications Section	
R2[1..1]	(Note 1)	Admission Medication History Section	1.3.6.1.4.1.19376.1.5.3.1.3.20	PCC Template See PCC TF Vol2 6.3.3.3.2 Admission Medication History Section	

IHE Patient Care Coordination Technical Framework Supplement – Patient Care Plan Content Profile (PtCP)

Template Name	<u>PtCP DOCUMENT</u>				
Template ID	<OID/UID> 1.3.6.1.4.1.19376.1.5.3.1.1.26.1				
Parent Template	IHE PCC MEDICAL DOCUMENT TEMPLATE (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1) Reconciliation Content template ID 1.3.6.1.4.1.19376.1.5.3.1.1.24.1 Note: This template ID should be used in documents that contain entries that have been reconciled.				
General Description	THE PATIENT CARE PLAN (PtCP) CONTENT PROFILE REPRESENTS THE SYNTHESIZED DATA THAT IS PRODUCED AS A RESULT OF MULTIPLE PLANS OF CARE PRODUCED BY EACH PROVIDER TO ADDRESS SPECIFIC HEALTH CONCERNS OF THE PATIENT.				
Document Code	SHALL be Code xxxxx-x, Code System, “Value Set name”> LOINC < Will utilize the same LOINC code as CCDA Care Plan document when available.				
Opt and Card	Condition	Header Element or Section Name	PCC Template ID	Specification Document	Vocabulary Constraint
R2[1..1]	(Note 1)	Discharge Diet section	1.3.6.1.4.1.19376.1.5.3.1.3.33	PCC Template See PCC TF Vol2 6.3.3.6.4 Discharge Diet Section	
O[0..1]	(Note 1)	Medications Administered	1.3.6.1.4.1.19376.1.5.3.1.3.21	PCC Template See PCC TF Vol2 6.3.3.3.3 Medications Administered Section	
R[1..1]	(Note 1)	Active Problem Section	1.3.6.1.4.1.19376.1.5.3.1.3.6	PCC Template See PCC TF Vol2 6.3.3.2.3 Active Problems Section	
R[1..1]	(Note 1)	Assessment and Plan Section	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5	PCC Template See PCC TF Vol2 6.3.3.6.2 Assessment and Plan Section	

IHE Patient Care Coordination Technical Framework Supplement – Patient Care Plan Content Profile (PtCP)

Template Name	<u>PtCP DOCUMENT</u>				
Template ID	<OID/UID> 1.3.6.1.4.1.19376.1.5.3.1.1.26.1				
Parent Template	IHE PCC MEDICAL DOCUMENT TEMPLATE (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1) Reconciliation Content template ID 1.3.6.1.4.1.19376.1.5.3.1.1.24.1 Note: This template ID should be used in documents that contain entries that have been reconciled.				
General Description	THE PATIENT CARE PLAN (PtCP) CONTENT PROFILE REPRESENTS THE SYNTHESIZED DATA THAT IS PRODUCED AS A RESULT OF MULTIPLE PLANS OF CARE PRODUCED BY EACH PROVIDER TO ADDRESS SPECIFIC HEALTH CONCERNS OF THE PATIENT.				
Document Code	SHALL be Code xxxxx-x, Code System, “Value Set name”> LOINC < Will utilize the same LOINC code as CCDA Care Plan document when available.				
Opt and Card	Condition	Header Element or Section Name	PCC Template ID	Specification Document	Vocabulary Constraint
R[1..1]	(Note 1)	Event Outcomes Section	1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9	PCC Suppl CDA Content 6.3.3.2.42 Event Outcomes Section	
R2[1..1]	(Note 1)	Discharge Diagnosis	1.3.6.1.4.1.19376.1.5.3.1.3.7	PCC Template See PCC TF Vol2 6.3.3.2.4 Discharge Diagnosis Section	
R2[1..1]	(Note 1)	Coded List of Surgeries	1.3.6.1.4.1.19376.1.5.3.1.3.12	PCC Template See PCC TF Vol2 6.3.3.2.10 Coded List of Surgeries Section	

IHE Patient Care Coordination Technical Framework Supplement – Patient Care Plan Content Profile (PtCP)

Template Name	<u>PtCP DOCUMENT</u>				
Template ID	<OID/UID> 1.3.6.1.4.1.19376.1.5.3.1.1.26.1				
Parent Template	IHE PCC MEDICAL DOCUMENT TEMPLATE (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1) Reconciliation Content template ID 1.3.6.1.4.1.19376.1.5.3.1.1.24.1 Note: This template ID should be used in documents that contain entries that have been reconciled.				
General Description	THE PATIENT CARE PLAN (PtCP) CONTENT PROFILE REPRESENTS THE SYNTHESIZED DATA THAT IS PRODUCED AS A RESULT OF MULTIPLE PLANS OF CARE PRODUCED BY EACH PROVIDER TO ADDRESS SPECIFIC HEALTH CONCERNS OF THE PATIENT.				
Document Code	SHALL be Code xxxxx-x, Code System, “Value Set name”> LOINC < Will utilize the same LOINC code as CCDA Care Plan document when available.				
Opt and Card	Condition	Header Element or Section Name	PCC Template ID	Specification Document	Vocabulary Constraint
R[1..1]	(Note 1)	Coded Results Section	1.3.6.1.4.1.19376.1.5.3.1.3.28	PCC Template See PCC TF Vol2 6.3.3.5.2 Coded Results Section	
O[0..1]	(Note 1)	Coded Hospital Studies Summary Section	1.3.6.1.4.1.19376.1.5.3.1.3.30	PCC Template See PCC TF Vol2 6.3.3.5.3.1 Coded Hospital Studies Summary Section	
O[0..1]	(Note 1)	Coded Advance Directives Section	1.3.6.1.4.1.19376.1.5.3.1.3.35	PCC Template See PCC TF Vol2 6.3.3.6.6 Coded Advance Directives Section	
O[0..1]	(Note 1)	Encounters Histories Section	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.3	PCC Template See PCC TF Vol2 6.3.3.2.6 Encounter Histories Section	
O[0..1]	(Note 1)	Coded Family Medical History Section	1.3.6.1.4.1.19376.1.5.3.1.3.15	PCC Template See PCC TF Vol2 6.3.3.2.13 Coded Family Medical History Section	
R2[0..1]	(Note 1)	Coded Functional Status Assessment Section	1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1	PCC Suppl CDA Content 6.3.3.2.22 Coded Functional Status Assessment Section	

IHE Patient Care Coordination Technical Framework Supplement – Patient Care Plan Content Profile (PtCP)

Template Name	<u>PtCP DOCUMENT</u>				
Template ID	<OID/UID> 1.3.6.1.4.1.19376.1.5.3.1.1.26.1				
Parent Template	IHE PCC MEDICAL DOCUMENT TEMPLATE (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1) Reconciliation Content template ID 1.3.6.1.4.1.19376.1.5.3.1.1.24.1 Note: This template ID should be used in documents that contain entries that have been reconciled.				
General Description	THE PATIENT CARE PLAN (PtCP) CONTENT PROFILE REPRESENTS THE SYNTHESIZED DATA THAT IS PRODUCED AS A RESULT OF MULTIPLE PLANS OF CARE PRODUCED BY EACH PROVIDER TO ADDRESS SPECIFIC HEALTH CONCERNS OF THE PATIENT.				
Document Code	SHALL be Code xxxxx-x, Code System, “Value Set name”> LOINC < Will utilize the same LOINC code as CCDA Care Plan document when available.				
Opt and Card	Condition	Header Element or Section Name	PCC Template ID	Specification Document	Vocabulary Constraint
R2[0..1]	(Note 1)	Assessment Section	1.3.6.1.4.1.19376.1.5.3.1.1.13.2.4	PCC Template See PCC Suppl CDA Content Modules 6.3.3.9.7 Assessments Section	
R2[0..1]	(Note 1)	Immunizations Section	1.3.6.1.4.1.19376.1.5.3.1.3.23	PCC Template See PCC TF Vol2 6.3.3.3.5 Immunizations Section	
O[0..1]	(Note 1)	Medical Devices Section	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.5	PCC Template See PCC TF Vol2 6.3.3.2.19 Medical Devices Section	
O[0..1]	(Note 1)	Payers Section	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7	PCC Template See PCC TF Vol2 6.3.3.7.1 Payers Section Coverage entry see PCC Suppl CDA Content 6.3.4.36 Coverage Entry 1.3.6.1.4.1.19376.1.5.3.1.4.17	
O[0..1]	(Note 1)	Social History Section	1.3.6.1.4.1.19376.1.5.3.1.3.16.1	PCC Suppl CDA Content 6.3.3.2.36 Coded Social History Section	

IHE Patient Care Coordination Technical Framework Supplement – Patient Care Plan Content Profile (PtCP)

Template Name	<u>PtCP DOCUMENT</u>				
Template ID	<OID/UID> 1.3.6.1.4.1.19376.1.5.3.1.1.26.1				
Parent Template	IHE PCC MEDICAL DOCUMENT TEMPLATE (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1) Reconciliation Content template ID 1.3.6.1.4.1.19376.1.5.3.1.1.24.1 Note: This template ID should be used in documents that contain entries that have been reconciled.				
General Description	THE PATIENT CARE PLAN (PtCP) CONTENT PROFILE REPRESENTS THE SYNTHESIZED DATA THAT IS PRODUCED AS A RESULT OF MULTIPLE PLANS OF CARE PRODUCED BY EACH PROVIDER TO ADDRESS SPECIFIC HEALTH CONCERNS OF THE PATIENT.				
Document Code	SHALL be Code xxxxx-x, Code System, “Value Set name”> LOINC < Will utilize the same LOINC code as CCDA Care Plan document when available.				
Opt and Card	Condition	Header Element or Section Name	PCC Template ID	Specification Document	Vocabulary Constraint
O[0..1]	(Note 1)	Vital Signs Section	1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2	PCC Template See PCC TF Vol2 6.3.3.4.5 Coded Vital Signs Section	
O[0..1]	(Note 1)	History of Past Illness	1.3.6.1.4.1.19376.1.5.3.1.3.8	PCC Template See PCC TF Vol2 6.3.3.2.5 History of Past Illness Section	
O[0..1]	(Note 1)	Review of System	1.3.6.1.4.1.19376.1.5.3.1.3.18	PCC Template See PCC TF Vol2 6.3.3.2.16 Review of Systems Section	
O[0..1]	(Note 1)	Physical Exam	1.3.6.1.4.1.19376.1.5.3.1.1.9.15	PCC Template See PCC TF Vol2 6.3.3.4.2 Detailed Physical Examination Section	
O[0..1]	(Note 1)	Hospital Discharge Physical Exam	1.3.6.1.4.1.19376.1.5.3.1.3.26	PCC Template See PCC TF Vol2 6.3.3.4.3 Hospital Discharge Physical Exam Section	
O[0..1]	(Note 1)	Hospital Discharge Instructions	1.3.6.1.4.1.19376.1.5.3.1.1.26.1.2		
R[1..1]	(Note 1)	Patient Care Plan Section	1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1		

Note 1: Because of current transition to universal content, CCDA templates and IHE templates are included in this guide. At the completion of the profile harmonizing the IHE PCC and CCDA templates, the referenced CCDA templates will be removed and the new harmonized templates will be used. See open issues.

985

Note 2: PtCP is a medical summary and inherits all header constraints from Medical Summaries. 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. CCDA US Realm header elements can be used when the CCDA flavor of templates are implemented.

990

Table 6.3.1.D.5-2 PtCP Document CCDA Content Module Specification

Template Name	PtCP Document				
Template ID	<oid/uid> 1.3.6.1.4.1.19376.1.5.3.1.1.27.1				
Parent Template	IHE PCC Medical Document template (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1) Reconciliation Content template ID 1.3.6.1.4.1.19376.1.5.3.1.1.24.1				
General Description	The Patient Care Plan (PtCP) content profile represents the synthesized data that is produced as a result of multiple plans of care produced by each provider to address specific health concerns of the patient.				
Document Code	SHALL be Code xxxxx-x, Code System, “Value Set name”> LOINC < Will utilize the same LOINC code as CCDA Care Plan document when available.				
Opt and Card	Condition	Header Element or Section Name	CCDA Template ID	Specification Document	Vocabulary Constraint
Header Elements					
R[1..1]	(Note 1)	Demographics	2.16.840.1.113883.10.20.22.1.1	CCDA Template see CCDA July 2012 2.2 US Realm Header See Note 2	NA
Sections					
R[1..1]	(Note 1)	Allergies Section	2.16.840.1.113883.10.20.22.2.6.1	CCDA Template see CCDA July 2012 4.2 Allergies Section 48765-2	
R[1..1]	(Note 1)	Medications Section	2.16.840.1.113883.10.20.22.2.1.1	CCDA Template see CCDA July 2012 4.33 Medications Section 10160-0	
R2[1..1]	(Note 1)	Hospital Discharge Medications Section	2.16.840.1.113883.10.20.22.2.11.1	CCDA Template see CCDA July 2012 4.24 Hospital Discharge Medications Section 10183-2	
R2[1..1]	(Note 1)	Discharge Diet section	1.3.6.1.4.1.19376.1.5.3.1.3.33	CCDA Template see CCDA July 2012 4.10 Discharge Diet Section 42344-2	

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O[0..1]	(Note 1)	Medications Administered	2.16.840.1.113883.10.20.22.2.38	CCDA Template see CCDA July 2012 4.32 Medications Administered Section 29549-3	
R[1..1]	(Note 1)	Health Concern Section	2.16.840.1.113883.10.20.22.2.58	CCDA Template see CCDA August 2013 2.22 Health Concerns Section	
R[1..1]	(Note 1)	Health Status Evaluations/Outcomes Section	2.16.840.1.113883.10.20.22.2.61	CCDA Template see CCDA August 2013 2.23 Health Status Evaluations/Outcomes Section	
R[1..1]	(Note 1)	Active Problem Section	2.16.840.1.113883.10.20.22.2.5.1	CCDA Template see CCDA July 2012 4.44 Problem Section 11450-4	
R2[1..1]	(Note 1)	Discharge Diagnosis	2.16.840.1.113883.10.20.22.2.24	CCDA Template see CCDA July 2012 4.22 Hospital Discharge Diagnosis Section 11535-2	
R2[1..1]	(Note 1)	Procedures Section	2.16.840.1.113883.10.20.22.2.7.1	CCDA Template see CCDA July 2012 4.52 Procedures Section 47519-4	
R[1..1]	(Note 1)	Results Section	2.16.840.1.113883.10.20.22.2.3.1	CCDA Template see CCDA July 2012 4.55 Results Section 30954-2	
O[0..1]	(Note 1)	Hospital Discharge Studies Summary Section	2.16.840.1.113883.10.20.22.2.16	CCDA Template see CCDA July 2012 4.26 Hospital Discharge Studies Summary Section 11493-4	
O[0..1]	(Note 1)	Advance Directives Section	2.16.840.1.113883.10.20.22.2.21.1	CCDA Template see CCDA July 2012 4.1 Advance Directives Section 42348-3	
O[0..1]	(Note 1)	Encounters Histories Section	2.16.840.1.113883.10.20.22.2.22.1	CCDA Template see CCDA July 2012 4.11 Encounters Section 46240-8	

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O[0..1]	(Note 1)	Family History Section	2.16.840.1.113883.10.20.22.2.15	CCDA Template see CCDA July 2012 4.12 Family History Section 10157-6	
R2[0..1]	(Note 1)	Functional Status Section	2.16.840.1.113883.10.20.22.2.14	CCDA Template see CCDA July 2012 4.14 Functional Status Section 47420-5	
R2[0..1]	(Note 1)	Assessment Section	2.16.840.1.113883.10.20.22.2.8	CCDA Template see CCDA July 2012 4.5 Assessment Section 51848-0	
O[0..1]	(Note 1)	Immunizations Section	2.16.840.1.113883.10.20.22.2.2.1	CCDA Template see CCDA July 2012 4.27 Immunizations Section 11369-6	
O[0..1]	(Note 1)	Medical Equipment Section	2.16.840.1.113883.10.20.22.2.23	CCDA Template see CCDA July 2012 4.30 Medical Equipment Section 46264-8	
O[0..1]	(Note 1)	Payers Section	2.16.840.1.113883.10.20.22.2.18	CCDA Template see CCDA July 2012 4.37 Payers Section 48768-6	
O[0..1]	(Note 1)	Social History Section	2.16.840.1.113883.10.20.22.2.17	CCDA Template see CCDA July 2012 4.57 Social History Section 29762-2	
O[0..1]	(Note 1)	Vital Signs Section	2.16.840.1.113883.10.20.22.2.4.1	CCDA Template see CCDA July 2012 4.60 Vital Signs Section 8716-3	
O[0..1]	(Note 1)	History of Past Illness	2.16.840.1.113883.10.20.22.2.20	CCDA Template see CCDA July 2012 4.16 History of Past Illness Section 11348-0	
O[0..1]	(Note 1)	Review of System	1.3.6.1.4.1.19376.1.5.3.1.3.18	CCDA Template see CCDA July 2012 4.56 Review of Systems Section 10187-3	
O[0..1]	(Note 1)	Physical Exam	2.16.840.1.113883.10.20.2.10	CCDA Template see CCDA July 2012 4.38 Physical Exam Section 29545-1	

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O[0..1]	(Note 1)	Hospital Discharge Physical Exam	1.3.6.1.4.1.19376.1.5.3.1.3.26	CCDA Template see CCDA July 2012 4.25 Hospital Discharge Physical Section 10184-0	
O[0..1]	(Note 1)	Instructions Section	2.16.840.1.113883.10.20.22.2.45	CCDA Template see CCDA July 2012 4.28 Instructions Section 69730-0	
O[0..1]	(Note 1)	Hospital Discharge Instructions	2.16.840.1.113883.10.20.22.2.41	CCDA Template see CCDA July 2012 4.23 Hospital Discharge Instructions Section 8653-8	
R[1..1]	(Note 1)	Patient Care Plan Section	1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1		

Note 1: Because of current transition to universal content, CCDA templates and IHE templates are included in this guide. At the completion of the profile harmonizing the IHE PCC and CCDA templates, the referenced CCDA templates will be removed and the new harmonized templates will be used. See open issues.

995 Note 2: PtCP is a medical summary and inherits all header constraints from Medical Summaries. 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. CCDA US Realm header elements can be used when the CCDA flavor of templates are implemented.

6.3.1.D.5.1 PtCP IHE Vocabulary Constraint or Condition

None

1000 6.3.1.D.5.2 PtCP CCDA Vocabulary Constraint or Condition

None

6.3.1.D.6 PtCP Conformance and Example

1005 CDA Release 2.0 documents that conform to the requirements of this document content module shall indicate their conformance by the inclusion of the <templateId- TBD> XML elements in the header of the document.

A CDA Document may conform to more than one template. This content module inherits from the PCC TF Medical Document, 1.3.6.1.4.1.19376.1.5.3.1.1.1, content modules and so must conform to the requirements of those templates as well this document specification, PtCP template, and template ID (TBD).

1010 A complete example of the Patient Care Plan Profile, PtCP Document Content Module is available on the IHE ftp server at: ftp://ftp.ihe.net/Patient_Care_Coordination/yr9_2013-2014/Technical%20Committee/ProfileWork/MCPC_WD/

Note that this is an example and is meant to be informative and not normative. This example shows the <templateId (OIDs)> elements for all of the specified templates.

1015 **PtCP Document Profile IHE Example**

```
1015 <component>
1020 <section>
1025 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1' />
1030 <id root=' ' extension=' ' />
1035 <code code='xxxxx-x' displayName='Patient Care Plan'
1040 codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
1045 <text>
1050 Text as described above
1055 </text>
1060 <component>
1065 <section>
1070 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.13' />
1075 <!-- Required Allergies Section -->
1080 </section>
1085 </component>
1090 <component>
1095 <section>
1100 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.19' />
1105 <!-- Required Medications Section -->
1110 </section>
1115 </component>
1120 <component>
1125 <section>
1130 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5' />
1135 <!-- Required Assessment and Plan Section -->
1140 </section>
1145 </component>
1150 <component>
1155 <section>
1160 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9' />
1165 <!-- Required Event Outcomes Section -->
1170 </section>
1175 </component>
1180 <component>
1185 <section>
1190 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.6' />
1195 <!-- Required Active Problems Section -->
1200 </section>
1205 </component>
1210 <component>
1215 <section>
1220 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.22' />
1225 <!-- Required if Known Hospital Discharge Medications Section -->
1230 </section>
1235 </component>
1240 <component>
1245 <section>
1250 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.33' />
1255 <!-- Required if Known Discharge Diet Section -->
1260 </section>
1265 </component>
1270 <component>
1275 <section>
1280 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.21' />
1285 <!-- Optional Medications Administered Section -->
1290 </section>
1295 </component>
1300 <component>
1305 <section>
1310 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.7' />
1315 <!-- Required if Known Discharge Diagnosis Section -->
1320 </section>
1325 </component>
1330 </component>
```

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```
1080     <section>
1085         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.12' />
1090         <!-- Required if Known Coded List of Surgeries Section -->
1095     </section>
1100 </component>
1105 <component>
1110     <section>
1115         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.28' />
1120         <!-- Required Coded Results Section -->
1125     </section>
1130 </component>
1135 <component>
1140     <section>
1145         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.30' />
1150         <!-- Optional Coded Hospital Studies Summary Section -->
1155     </section>
1160 </component>
1165 <component>
1170     <section>
1175         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.35' />
1180         <!-- Required if Known Coded Advance Directives Section -->
1185     </section>
1190 </component>
1195 <component>
1200     <section>
1205         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.3' />
1210         <!-- Optional Encounters Histories Section-->
1215     </section>
1220 </component>
1225 <component>
1230     <section>
1235         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.15' />
1240         <!-- Optional Coded Family Medical History Section -->
1245     </section>
1250 </component>
1255 <component>
1260     <section>
1265         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1' />
1270         <!-- Required if Known Coded Functional Status Assessment Section-->
1275     </section>
1280 </component>
1285 <component>
1290     <section>
1295         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.4' />
1300         <!-- Required if Known Assessment Section-->
1305     </section>
1310 </component>
1315 <component>
1320     <section>
1325         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.23' />
1330         <!-- Optional Immunizations Section -->
1335     </section>
1340 </component>
1345 <component>
1350     <section>
1355         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.5' />
1360         <!-- Optional Medical Devices Section-->
1365     </section>
1370 </component>
1375 <component>
1380     <section>
1385         <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.7' />
1390         <!-- Optional Payers Section -->
1395     </section>
1400 </component>
```

```
1145 <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.16.1' />
        <!-- Optional Social History Section -->
      </section>
1150 </component>
      <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.2' />
          <!-- Optional Vital Signs Section -->
1155 </section>
        </component>
      <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.8' />
          <!-- Optional History of Past Illness Section -->
1160 </section>
        </component>
      <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.18' />
          <!-- Optional Review of System Section -->
1165 </section>
        </component>
      <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15' />
          <!-- Optional Physical Exam Section -->
1170 </section>
        </component>
      <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.26' />
          <!-- Optional Hospital Discharge Physical Exam Section -->
1175 </section>
        </component>
      <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.2' />
          <!-- Required if Known Hospital Discharge Instructions -->
1180 </section>
        </component>
      <component>
        <section>
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1' />
          <!-- Required Patient Care Plan Section -->
1185 </section>
        </component>
      </component>
1190 </section>
</component>
```

1195 **Figure 6.3.1.D.6-1: Specification for PtCP Document Profile (Using IHE Templates)**

PtCP Document Profile CCDA Example

```
1200 <component>
      <section>
1205   <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1' />
      <id root=' ' extension=' ' />
      <code code='xxxxx-x' displayName='Patient Care Plan'
        codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
      <text>
1205   Text as described above
      </text>
      <component>
        <section>
1210   <templateId root='2.16.840.1.113883.10.20.22.2.6.1' />
        <!-- Required Allergies Section -->
        </section>
      </component>
      <component>
        <section>
1215   <templateId root='2.16.840.1.113883.10.20.22.2.1.1' />
        <!-- Required Medications Section -->
        </section>
      </component>
      <component>
        <section>
1220   <templateId root='2.16.840.1.113883.10.20.22.2.5.1' />
        <!-- Required Active Problems Section -->
        </section>
      </component>
      <component>
        <section>
1225   <templateId root='2.16.840.1.113883.10.20.22.2.58' />
        <!-- Required Health Concern Section -->
        </section>
      </component>
      <component>
        <section>
1230   <templateId root='2.16.840.1.113883.10.20.22.2.61' />
        <!-- Required Health Status Evaluations/Outcomes Section -->
        </section>
      </component>
      <component>
        <section>
1235   <templateId root='2.16.840.1.113883.10.20.22.2.11.1' />
        <!-- Required if Known Hospital Discharge Medications Section -->
        </section>
      </component>
      <component>
        <section>
1240   <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.33' />
        <!-- Required if Known Discharge Diet section -->
        </section>
      </component>
      <component>
        <section>
1245   <templateId root='2.16.840.1.113883.10.20.22.2.38' />
        <!-- Optional Medications Administered Section -->
        </section>
      </component>
      <component>
        <section>
1250   <templateId root='2.16.840.1.113883.10.20.22.2.24' />
        <!-- Required if Known Discharge Diagnosis Section -->
        </section>
      </component>
1255   </component>
1260 </component>
```

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```
1265     <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.7.1' />
        <!-- Required if Known Procedures Section -->
    </section>
</component>
<component>
    <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.3.1' />
        <!-- Required Results Section -->
    </section>
</component>
<component>
    <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.16' />
        <!-- Optional Hospital Discharge Studies Summary Section -->
    </section>
</component>
<component>
    <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.21.1' />
        <!-- Required if Known Advance Directives Section -->
    </section>
</component>
1285 <component>
    <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.22.1' />
        <!-- Optional Encounters Histories Section -->
    </section>
</component>
1290 <component>
    <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.15' />
        <!-- Optional Family History Section -->
    </section>
</component>
<component>
    <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.14' />
        <!-- Required if Known Functional Status Section -->
    </section>
</component>
<component>
    <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.8' />
        <!-- Required if Known Assessment Section -->
    </section>
</component>
1310 <component>
    <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.2.1' />
        <!-- Optional Immunizations Section -->
    </section>
</component>
1315 <component>
    <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.23' />
        <!-- Optional Medical Equipment Section -->
    </section>
</component>
1320 <component>
    <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.18' />
        <!-- Optional Payers Section -->
    </section>
1325 </component>
```

```
1330 <component>
      <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.17' />
        <!-- Optional Social History Section -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.4.1' />
        <!-- Optional Vital Signs Section -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='2.16.840.1.113883.10.20.22.2.20' />
        <!-- Optional History of Past Illness Section -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.18' />
        <!-- Optional Review of System Section -->
      </section>
    </component>
    <component>
      <section>
        <templateId root=' 2.16.840.1.113883.10.20.2.10' />
        <!-- Optional Physical Exam Section -->
      </section>
    </component>
    <component>
      <section>
        <templateId root=' 1.3.6.1.4.1.19376.1.5.3.1.3.26' />
        <!-- Optional Hospital Discharge Physical Exam Section -->
      </section>
    </component>
    <component>
      <section>
        <templateId root=' 2.16.840.1.113883.10.20.22.2.45' />
        <!-- Required if Known Instructions Section -->
      </section>
    </component>
    <component>
      <section>
        <templateId root=' 2.16.840.1.113883.10.20.22.2.41' />
        <!-- Required if Known Hospital Discharge Instructions Section -->
      </section>
    </component>
    <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1' />
        <!-- Required Patient Care Plan Section -->
      </section>
    </component>
  </section>
</component>
```

Figure 6.3.1.D.6-2: Specification for PtCP Document Profile (Using CCDA Templates)

1385 *Add to section 6.3.2 Header Content Modules*

6.3.2 CDA Header Content Modules

6.3.2.H PtCP Header Content Module

No new Header elements.

6.3.3 CDA Section Content Modules

1390

Add to section 6.3.3.10 Section Content Modules

6.3.3.10.S1 Patient Care Plan - Section Content Module

Table 6.3.3.10.S1-1: Patient Care Plan Section

Template Name		Patient Care Plan Section				
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1				
Parent Template						
General Description		<p>The Patient Care Plan section contains one or more sub-sections which include:</p> <ul style="list-style-type: none"> • Plan of Care sections from providers • Reconciled Plan of Care sub-section which is used to consolidate the multiple Plans of Treatment included in the same Patient Care Plan section • Patient Goals sub-section which contains contain a description of the progress towards completing expectations for care including actions completed in fulfillment of proposals, goals, and order requests for monitoring, tracking, or improving the condition of the patient • Intervention sub-section which contains contain a description of the actions taken towards completing expectations for care including actions completed in fulfillment of proposals, goals, and order requests for monitoring, tracking, or improving the condition of the patient 				
Section Code		SHALL be Code xxxxx-x, Code System, "Value Set name"> LOINC < Will utilize the same LOINC code as PtCP document when available.				
Opt and Card	Condition	Data Element or Section Name	CCDA Template ID	PCC Template ID	Specificati on Document	Vocabula ry Constrai nt
Subsections						
C [1..*]	6.3.3.10.S.1 (note 1)	Care Plan Section	2.16.840.1.113883.1 0.20.22.2.10.2	1.3.6.1.4.1.19376.1 .5.3.1.3.31	PCC Template See PCC Suppl CDA Content 6.3.3.6.15 Care Plan Section	

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		Plan of Treatment Section			see CCDA August 2013 2.51 Plan of Treatment Section	
C[1..1]	6.3.3.10.S.2	Reconciled Plan of Care Section	1.3.6.1.4.1.19376.1.5 .3.1.1.26.1.4	1.3.6.1.4.1.19376.1 .5.3.1.1.26.1.4		
C [1..*]	6.3.3.10.S.3 (note 1)	Patient Goals Section	2.16.840.1.113883.1 0.20.22.2.60	1.3.6.1.4.1.19376.1 .5.3.1.1.26.1.3	see CCDA August 2013 2.18 Goals Section	
C[1..1]	6.3.3.10.S.4	Reconciled Patient Goals	1.3.6.1.4.1.19376.1.5 .3.1.1.26.1.5	1.3.6.1.4.1.19376.1 .5.3.1.1.26.1.5		
C [1..*]	(note 1)	Interventions Section	2.16.840.1.113883.1 0.20.21.2.3.2	1.3.6.1.4.1.19376.1 .5.3.1.1.13.2.11	PCC Template See PCC CDA Content Modules Supplement: 6.3.3.8.3 Procedures and Interventions Section see CCDA August 2013 2.35 Interventions Section	
C[1..1]	6.3.3.10.S6	Reconciled Interventions Section	1.3.6.1.4.1.19376.1.5 .3.1.1.26.1.6	1.3.6.1.4.1.19376.1 .5.3.1.1.26.1.6		

1395

Note 1: Because of current transition to universal content, CCDA templates and IHE templates are included in this guide. At the completion of the profile harmonizing the IHE PCC and CCDA templates, the referenced CCDA templates will be removed and the new harmonized templates will be used. See open issues.

1400 **6.3.3.10.S1.1 Plan of Care Section Condition, Specification Document, or Vocabulary Constraint**

Plan of Care section SHALL NOT be used as a section outside of the Patient Care Plan section.

1405 **6.3.3.10.S1.2 Reconciled Plan of Care Section Condition, Specification Document, or Vocabulary Constraint**

Reconciled Plan of Care section SHALL NOT be used as a section outside of the Patient Care Plan section.

6.3.3.10.S1.3 Patient Goals Section Condition, Specification Document, or Vocabulary Constraint

Patient Goal section SHALL NOT be used as a section outside of the Patient Care Plan section.

1410 **6.3.3.10.S1.4 Reconciled Patient Goals Section Condition, Specification Document, or Vocabulary Constraint**

Reconciled Patient Goal section SHALL NOT be used as a section outside of the Patient Care Plan section.

6.3.3.10.S1.5 Intervention Section Condition, Specification Document, or Vocabulary Constraint

1415 Intervention section SHALL NOT be used as a section outside of the Patient Care Plan section.

6.3.3.10.S1.6 Reconciled Intervention Section Condition, Specification Document, or Vocabulary Constraint

Reconciled Intervention section SHALL NOT be used as a section outside of the Patient Care Plan section.

1420

1425

1430 **Patient Care Plan Section IHE Example**

```
1430 <component>
1435 <section>
1435 <templateId root=' 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1' />
1435 <id root=' ' extension=' ' />
1435 <code code='xxxxx-x' displayName='Patient Care Plan'
1435 codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
1435 <text>
1435 Text as described above
1440 </text>
1440 <component>
1440 <section>
1440 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.31' />
1440 <!-- Required Plan of Care Section -->
1445 </section>
1445 </component>
1445 <component>
1445 <section>
1445 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.4' />
1450 <!-- Required if known Reconciled Plan of Care Section -->
1450 </section>
1450 </component>
1450 <component>
1450 <section>
1455 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.3' />
1455 <!-- Required if known Patient Goals Section -->
1455 </section>
1455 </component>
1455 <component>
1455 <section>
1460 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.5' />
1460 <!-- Required if known Reconciled Patient Goals Section -->
1460 </section>
1460 </component>
1465 <component>
1465 <section>
1465 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11' />
1465 <!-- Required if known Intervention Section -->
1470 </section>
1470 </component>
1470 <component>
1470 <section>
1475 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.6' />
1475 <!-- Required if known Reconciled Intervention Section -->
1475 </section>
1475 </component>
1475 </section>
1475 </component>
```

Figure 6.3.3.10.S1.3-1: Specification for Patient Care Plan Section (Using IHE Templates)

1480

1485

Patient Care Plan Section CCDA Example

```
1490 <component>
      <section>
        <templateId root=' 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1' />
        <id root=' ' extension=' ' />
        <code code='xxxxx-x' displayName='Patient Care Plan'
1495         codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
        <text>
          Text as described above
        </text>
        <component>
          <section>
            <templateId root='2.16.840.1.113883.10.20.22.2.10.2' />
            <!-- Required Plan of Treatment Section -->
            </section>
          </component>
          <component>
            <section>
              <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.4' />
              <!-- Required if known Reconciled Plan of Care Section -->
              </section>
            </component>
            <component>
              <section>
                <templateId root='2.16.840.1.113883.10.20.22.2.60' />
                <!-- Required if known Patient Goals Section -->
                </section>
              </component>
              <component>
                <section>
                  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.5' />
                  <!-- Required if known Reconciled Patient Goals Section -->
                  </section>
                </component>
                <component>
                  <section>
                    <templateId root='2.16.840.1.113883.10.20.21.2.3.2' />
                    <!-- Required if known Intervention Section -->
                    </section>
                  </component>
                  <component>
                    <section>
                      <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.6' />
                      <!-- Required if known Reconciled Intervention Section -->
                      </section>
                    </component>
                  </section>
                </component>
              </section>
            </component>
          </section>
        </component>
      </section>
    </component>
```

Figure 6.3.3.10.S1.3-2: Specification for Patient Care Plan Section (Using CCDA Templates)

1540

6.3.3.10.S2 Reconciled Plan of Care - Section Content Module

Table 6.3.3.10.S2-1 Reconciled Plan of Care Section (Using IHE Templates)

Template Name		Reconciled Plan of Care Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.26.1.4			
Parent Template		TBD (Parent is IHE Care Plan Section template ID) Care Plan Section 1.3.6.1.4.1.19376.1.5.3.1.3.31			
General Description		Reconciled Plan of Care section provides the patient-centered holistic view which results from the reconciliation of all the various Plans of Care.			
Section Code		<LOINC, "Reconciled Plan of Care Section"> 18776-5			
Opt and Card	Condition	Data Element or Section Name	IHE Template ID	Specificati on Document	Vocabulary Constraint
Entries					
C [1..*]		Health Maintenance Care Plan Section	1.3.6.1.4.1.19376.1.5.3.1.1.9.50	PCC Template See PCC Suppl CDA Content 6.3.3.6.9 Health Maintenance Care Plan Section	
C [1..*]		Encounter	1.3.6.1.4.1.19376.1.5.3.1.4.14	PCC Template See PCC Suppl CDA Content 6.3.3.6.15 Care Plan Section	
C [1..*]		Observation Requests	1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1	PCC Template See PCC Suppl CDA Content 6.3.3.6.15 Care Plan Section	
C [1..*]		Procedure	1.3.6.1.4.1.19376.1.5.3.1.4.19	PCC Template See PCC Suppl CDA Content 6.3.3.6.15 Care Plan Section	

C [1..*]		Medication	1.3.6.1.4.1.19376.1 .5.3.1.4.7	PCC Template See PCC Suppl CDA Content 6.3.3.6.15 Care Plan Section	
C [1..*]		Immunization	1.3.6.1.4.1.19376.1 .5.3.1.4.12	PCC Template See PCC Suppl CDA Content 6.3.3.6.15 Care Plan Section	
C [1..*]		Medical Devices Section	1.3.6.1.4.1.19376.1 .5.3.1.1.5.3.5	PCC Template See PCC TF Vol2 6.3.3.2.19 Medical Devices Section	

1545

Table 6.3.3.10.S2-2 Reconciled Plan of Care Section (Using CCDA Templates)

Template Name		Reconciled Plan of Care Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.26.1.4			
Parent Template		Parent is CCDA Plan of Treatment Section (V2) template ID 2.16.840.1.113883.10.20.22.2.10.2			
General Description		Reconciled Plan of Care section provides the patient-centered holistic view which results from the reconciliation of all the various Plans of Care.			
Section Code		<LOINC, “Reconciled Plan of Care Section”> 18776-5			
Opt and Card	Condition	Data Element or Section Name	CCDA Template ID	Specificati on Document	Vocabulary Constraint
Entries					
C [1..*]		Instructions	2.16.840.1.113883. 10.20.22.4.20.2	CCDA Template see CCDA August 2013 3.42 Instructions	

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C [1..*]		Act Plan	2.16.840.1.113883.10.20.22.4.39.2	CCDA Template see CCDA August 2013 3.1 Act Plan	
C [1..*]		Encounter Plan	2.16.840.1.113883.10.20.22.4.40.2	CCDA Template see CCDA August 2013 3.26 Encounter Plan	
C [1..*]		Handoff Communication	2.16.840.1.113883.10.20.22.4.141	CCDA Template see CCDA August 2013 3.17.1 Handoff Communication	
C [1..*]		Observation Plan	2.16.840.1.113883.10.20.22.4.44.2	CCDA Template see CCDA August 2013 3.54 Observation Plan	
C [1..*]		Procedure Plan	2.16.840.1.113883.10.20.22.4.41.2	CCDA Template see CCDA August 2013 3.72 Procedure Plan	
C [1..*]		Substance Administration Plan	2.16.840.1.113883.10.20.22.4.42.2	CCDA Template see CCDA August 2013 3.91 Substance Administration Plan	

C [1..*]		Supply Plan	2.16.840.1.113883.10.20.22.4.43.2	CCDA Template see CCDA August 2013 3.93 Supply Plan	
----------	--	-------------	-----------------------------------	---	--

1550 **6.3.3.10.S2.1 Reconciled Plan of Care Section (Using IHE Templates) Condition, Specification Document, or Vocabulary Constraint**

None

6.3.3.10.S2.2 Reconciled Plan of Care Section (Using CCDA Templates) Condition, Specification Document, or Vocabulary Constraint

None

1555

Reconciled Plan of Care IHE Templates

```

1560 <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.4' />
        <id root=' ' extension=' '/>
        <code code='18776-5' displayName='Reconciled Plan of Care'
          codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
        <text>
1565   Text as described above
        </text>
        <entry>
          :
1570   <!--Optional Health Maintenance Care Plan Section content-->
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.50' />
          :
        </entry>
        <entry>
          :
1575   <!--Optional Encounter Entry -->
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.14' />
          :
        </entry>
        <entry>
          :
1580   <!--Optional Observation Requests Entry -->
          <templateId root=' 1.3.6.1.4.1.19376.1.5.3.1.1.20.3.1' />
          :
        </entry>
        <entry>
          :
1585   <!--Optional Procedure Entry -->
          <templateId root=' 1.3.6.1.4.1.19376.1.5.3.1.4.19' />
          :
        </entry>
        <entry>
          :
1590   <!--Optional Medication Entry -->
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.7' />
          :
1595   </entry>
        <entry>
          :
1600   <!--Optional Immunization Entry -->
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.12' />
          :
        </entry>
        <entry>
          :
1605   <!--Optional Plan Medical DevicesSection -->
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.5' />
          :
        </entry>
      </section>
    </component>
1610
  
```

Figure 6.3.3.10.S2.2-1: Specification for Reconciled Plan of Care Section (Using IHE Templates)

Reconciled Plan of Care CCDA Example

```
1615 <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.4' />
        <id root=' ' extension=' ' />
        <code code='18776-5' displayName='Reconciled Plan of Care'
1620         codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
        <text>
          Text as described above
        </text>
        <entry>
          :
1625         <!--Optional Instructions Entry -->
          <templateId root='2.16.840.1.113883.10.20.22.4.20.2' />
          :
        </entry>
        <entry>
          :
1630         <!--Optional Act Plan Entry -->
          <templateId root='2.16.840.1.113883.10.20.22.4.39.2' />
          :
        </entry>
        <entry>
          :
1635         <!--Optional Encounter Plan Entry -->
          <templateId root=' 2.16.840.1.113883.10.20.22.4.40.2' />
          :
        </entry>
        <entry>
          :
1640         <!--Optional Handoff Communication Entry -->
          <templateId root='2.16.840.1.113883.10.20.22.4.141' />
          :
1645         </entry>
        <entry>
          :
1650         <!--Optional Observation Plan Entry -->
          <templateId root='2.16.840.1.113883.10.20.22.4.44.2' />
          :
        </entry>
        <entry>
          :
1655         <!--Optional Procedure Plan Entry -->
          <templateId root='2.16.840.1.113883.10.20.22.4.41.2' />
          :
        </entry>
        <entry>
          :
1660         <!--Optional Substance Administration Plan Entry -->
          <templateId root='2.16.840.1.113883.10.20.22.4.42.2' />
          :
        </entry>
        <entry>
          :
1665         <!--Optional Supply Plan Entry -->
          <templateId root='2.16.840.1.113883.10.20.22.4.43.2' />
          :
1670         </entry>
      </section>
    </component>
```

Figure 6.3.3.10.S2.2-2: Specification for Reconciled Plan of Care Section (Using CCDA Templates)

1675 **6.3.3.10.S3 Patient Goals - Section Content Module**

Table 6.3.3.10.S3-1: Patient Goals Section (using IHE template)

Template Name		Patient Goals Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.26.1.3			
Parent Template					
General Description		Patient goals section shall contain a description of the progress towards completing expectations for care including actions completed in fulfillment of proposals, goals, and order requests for monitoring, tracking, or improving the condition of the patient.			
Section Code		LOINC, “Patient Goals Section”> 61146-7			
Opt and Card	Condition	Data Element or Section Name	Template ID	Specification Document	Vocabulary Constraint
Text only section					

1680 **6.3.3.10.S3.1 Patient Goals Section Condition, Specification Document, or Vocabulary Constraint**

None

Patient Goals IHE Example

```

1685 <component>
      <section>
1690   <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.3' />
      <id root=' ' extension=' ' />
      <code code='61146-7' displayName='PATIENT GOALS'
1695   codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
      <text>
        Text as described above
      </text>
      </section>
    </component>
  
```

Figure 6.3.3.10.S3.1-1: Specification for IHE Patient Goals Section

1700

6.3.3.10.S4 Reconciled Patient Goals - Section Content Module

Table 6.3.3.10.S4-1: Reconciled Patient Goals Section (Using IHE Templates)

Template Name		Reconciled Patient Goals Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.26.1.5			
Parent Template					
General Description		Reconciled Patient Goals section provides the patient-centered holistic view which results from the reconciliation of all the various Goals sections.			
Section Code		<LOINC, “Reconciled Patient Goals Section”> 61146-7			
Opt and Card	Condition	Data Element or Section Name	IHE Template ID	Specification on Document	Vocabulary Constraint
Text only section					

1705

Table 6.3.3.10.S4-2: Reconciled Patient Goals Section (using CCDA template)

Template Name		Reconciled Patient Goals Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.26.1.5			
Parent Template		Parent is CCDA Goals Section template ID 2.16.840.1.113883.10.20.22.2.60			
General Description		Reconciled Patient Goals section provides the patient-centered holistic view which results from the reconciliation of all the various Goals sections.			
Section Code		<LOINC, “Reconciled Patient Goals Section”> 61146-7			
Opt and Card	Condition	Data Element or Section Name	CCDA Template ID	Specification on Document	Vocabulary Constraint
Entries					
R [1..*]		Goal Observation	2.16.840.1.113883.10.20.22.4.121	CCDA Template see CCDA August 2013 3.54.1 Goal Observation	

Reconciled Patient Goals IHE Example

```

1710 <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.5' />
        <id root=' ' extension=' ' />
        <code code='61146-7' displayName='Goals'
          codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
        <text>
1715   Text as described above
        </text>
        <component>
          <section>
1720     <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.3' />
           <!-- Required Goals Section -->
          </section>
        </component>
      </section>
    </component>
  
```

Figure 6.3.3.10.S4-1: Specification for IHE Reconciled Patient Goals Section

1725

Reconciled Patient Goals CCDA Example

```

1730 <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.5' />
        <id root=' ' extension=' ' />
        <code code='61146-7' displayName='Goals'
          codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
        <text>
1735   Text as described above
        </text>
        <entry>
          :
1740     <!--Required Goal Observation Entry -->
           <templateId root='2.16.840.1.113883.10.20.22.4.121' />
          :
        </entry>
      </section>
    </component>
  
```

Figure 6.3.3.10.S4-2: Specification for CCDA Reconciled Patient Goals Section

1745

6.3.3.10.S5 Hospital Discharge Instructions - Section Content Module

Table 6.3.3.10.S5-1: Hospital Discharge Instructions

Template Name	Hospital Discharge Instructions
Template ID	1.3.6.1.4.1.19376.1.5.3.1.1.26.1.2
Parent Template	
General Description	The Hospital Discharge Instructions section records instructions at discharge.
Section Code	<TBD, LOINC, "Hospital Discharge Instructions"> 8653-8 HOSPITAL DISCHARGE INSTRUCTIONS

Opt and Card	Condition	Data Element or Section Name	Template ID	Specification Document	Vocabulary Constraint
Text only section					

1750 **6.3.3.10.S5.1 Hospital Discharge Instructions Condition, Specification Document, or Vocabulary Constraint**

None

```

1755 <component>
    <section>
      <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.2' />
      <id root=' ' extension=' ' />
      <code code='8653-8' displayName='HOSPITAL DISCHARGE INSTRUCTIONS'
1760       codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
      <text>
        Text as described above
      </text>
    </section>
  </component>

```

Figure 6.3.3.10.S5.1-1: Specification for Hospital Discharge Instructions Section

1765

6.3.3.10.S6 Reconciled Interventions- Section Content Module

Table 6.3.3.10.S6-1: Reconciled Interventions Section (Using IHE Templates)

Template Name		Reconciled Intervention Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.26.1.6			
Parent Template		Parent is IHE Procedures and Interventions template ID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11			
General Description		Reconciled Intervention section provides the patient-centered holistic view which results from the reconciliation of all the various Intervention sections.			
Section Code		<LOINC, "Reconciled Intervention Section"> 62387-6			
Opt and Card	Condition	Data Element or Section Name	CCDA Template ID	Specification Document	Vocabulary Constraint
Entries					

R [1..*]		Procedure	1.3.6.1.4.1.19376.1.5.3.1.4.19	PCC Template See PCC Suppl CDA Content 6.3.3.8.3 Procedures and Interventions Section	
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1770

Table 6.3.3.10.S6-2: Reconciled Interventions Section (using CCDA template)

Template Name		Reconciled Intervention Section			
Template ID		1.3.6.1.4.1.19376.1.5.3.1.1.26.1.6			
Parent Template		Parent is CCDA Intervention template ID 2.16.840.1.113883.10.20.21.2.3.2			
General Description		Reconciled Intervention section provides the patient-centered holistic view which results from the reconciliation of all the various Intervention sections.			
Section Code		<LOINC, "Reconciled Intervention Section"> 62387-6			
Opt and Card	Condition	Data Element or Section Name	CCDA Template ID	Specificati on Document	Vocabulary Constraint
Entries					
R [1..*]		Intervention Act	2.16.840.1.113883.10.20.22.4.131	CCDA Template see CCDA August 2013 3.43 Intervention Act	

Reconciled Interventions IHE Example

```
1775 <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.6' />
        <id root=' ' extension=' ' />
        <code code='62387-6' displayName='Interventions'
          codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
1780 <text>
          Text as described above
        </text>
        <entry>
          :
1785 <!--Required Procedure Entry -->
          <templateId root='1.3.6.1.4.1.19376.1.5.3.1.4.19' />
          :
        </entry>
      </section>
    </component>
```

1790 **Figure 6.3.3.10.S6-1: Specification for IHE Reconciled Interventions Section**

Reconciled Interventions CCDA Example

```
1795 <component>
      <section>
        <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.26.1.6' />
        <id root=' ' extension=' ' />
        <code code='62387-6' displayName='Interventions'
          codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC' />
1800 <text>
          Text as described above
        </text>
        <entry>
          :
1805 <!--Required Intervention Act Entry -->
          <templateId root='2.16.840.1.113883.10.20.22.4.131' />
          :
        </entry>
      </section>
    </component>
```

1810 **Figure 6.3.3.10.S6-2: Specification for IHE Reconciled Interventions Section**

6.3.4 CDA Entry Content Modules

No new entries.

6.4 Section not applicable

1815 This heading is not currently used in a CDA document.

6.5 PCC Value Sets

No value sets.

Appendices

None

1820

Volume 3 Namespace Additions

Add the following terms to the IHE Namespace:

The following new template OIDs are defined specifically for this profile:

1825

- Patient Care Plan Document OID (IHE flavor) - 1.3.6.1.4.1.19376.1.5.3.1.1.26.1
- Patient Care Plan Document OID (CCDA flavor) - 1.3.6.1.4.1.19376.1.5.3.1.1.27.1
- Reconciled Plan of Care Section OID - 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.4
- Patient Care Plan Section OID - 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.1
- Hospital Discharge Instructions Section OID - 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.2

1830

- Patient Goals Section OID - 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.3
- Reconciled Patient Goals OID – 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.5
- Reconciled Interventions OID – 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.6

1835

Volume 4 – National Extensions

Add appropriate Country section

4 National Extensions

1840 Not applicable