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HL7 CDA® R2 Implementation Guide: C-CDA R2.1 Supplemental Templates for Advance Directives, Release 1, STU2 - US Realm

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HL7 STU

Sponsored by:
Structured Documents (SD) Work Group

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Structure of This Guide

The *HL7 CDA® Release 2 Implementation Guide: Consolidated CDA Advance Directives Templates* provides narrative introductory and background material pertinent to this IG, including information on how to understand and use the templates. It also contains the normative Clinical Document Architecture (CDA) templates for this guide along with lists of all templates, code systems, value sets, and changes from the previous version.

Table of Contents

Part I. C-CDA R2.1 – Advance Directives Templates

Substantive Changes in this Version

	Summary
1	Major copy rewrites were done to align the IG with work being developed in the overarching HL7 FHIR PACIO Advance Directive Interoperability Implementation Guide.
2	Use Cases were removed and now point to HL7 FHIR PACIO Advance Directive Interoperability Implementation Guide Use Cases by reference.
3	Content was changed to clarify the purpose of this IG is solely on how the HL7 FHIR PACIO Advance Directive Interoperability Implementation Guide defines Type-2 Content. Readers are now directed to the HL7 CDA® R2 Implementation Guide: Personal Advance Care Plan (PACP) Document, Release 1 - US Realm and HL7 CDA R2 Implementation Guide: ePOLST: Portable Medical Orders About Resuscitation and Initial Treatment on implementing Type-1 (patient-authored) and CDA Type-3 (practitioner-authored) Content related to CDA documents.
4	Best Practice guidance for the use of C-CDA Advance Directive templates is now highlighted with a visual call-out treatment that makes the conformance expectations easier to find.

Open Issues

	Description
1	Links to the HL7 FHIR PACIO Advance Directive Interoperability Implementation Guide and HL7 CDA R2 Implementation Guide: ePOLST: Portable Medical Orders About Resuscitation and Initial Treatment have not been included because these works are not yet published in final form. Once they are available, a minor update to this IG will be done to include those reference links

Introduction

This implementation guide (IG) defines new versions of the four (4) C-CDA templates used to represent a patient's advance directive information referenced and verified by a care team member during a care encounter. It also defines three (3) new templates used to represent advance directive information collected and accessible during that encounter, pertinent for care delivery and planning.

The IG describes how to use these C-CDA supplemental templates to exchange information about an individual's documented advanced medical goals, preferences, and priorities for care which can be consulted by healthcare providers in the event the individual is unable to communicate this information to the medical team during a health crisis. It also describes how to represent decisions which are pertinent to an episode of care made by a patient or a patient's healthcare agent, and how to represent advance care planning activities performed by a practitioner.

Note: The term "advance directive" in this IG does not refer to a specific form, document, or method of memorializing advance healthcare decisions, but is instead an overarching term used to describe all types of advance directive information. Advance directive information can be organized into three distinct categories. The HL7 FHIR PACIO Advance Directive Interoperability Implementation Guide defines these three categories as:

- Content Type 1: Person-Authored Advance Directive Information,

- Content Type 2: Encounter-Centric Documentation of existing Patient Care Goals and Treatment preferences and Current Instructions (obligations and prohibitions). and
- Content Type 3: Portable Medical Orders for Life-Sustaining Treatment.

This IG focuses on defining a standard representation for Type 2 Content, to facilitate exchange, sharing, and retrieval of this information. It covers data exchange, sharing and retrieval of Advance Directive Content Type 2: Encounter-Centric Documentation of existing Patient Care Goals and Treatment preferences and Current Instructions. While the IG describes the provider's documentation of the presence of Advance Directive Content Type 1: Person-Authored Advance Directive Information and Advance Directive Content Type 3: Portable Medical Orders for Life-Sustaining Treatment, it does not define the templates used for representing Type 1 or Type 3 Advance Directive documents.

For additional information on Type 1 Advance Directive content, please reference the current version of the HL7 CDA® R2 Implementation Guide: Personal Advance Care Plan (PACP) IG and for additional information on Type 3 Advance Directive content, please see HL7 CDA R2 Implementation Guide: ePOLST: Portable Medical Orders About Resuscitation and Initial Treatment.

Purpose

This version of the IG does not define any additional templates. Modifications have been made to align this work with additional advance directive data exchange standardization taking place in the HL7 FHIR PACIO Advance Directive Interoperability Implementation Guide] and HL7 CDA R2 Implementation Guide: ePOLST: Portable Medical Orders About Resuscitation and Initial Treatment and clarify how this guidance fits in with the entire body of advance directive data exchange guidance being developed within HL7.

How are the new versions and new advance directive templates expected to be used?

As recognition of the value of advance directive information in clinical care has expanded by both patients and providers, inclusion of advance directive information in clinical documents and data exchange has become more important. This IG establishes new best practices for using advance directive templates by clinicians and care teams. When generating C-CDA Documents, follow this stronger conformance guidance:

	Transfer Summary - SHALL include Advance Directives Section (V4) (entries required).[CONF:AD-001]
	Procedure Note - SHALL include Advance Directives Section (V4) (entries optional). [CONF:AD-002]
	Operative Note - SHALL include Advance Directives Section (V4) (entries optional). [CONF:AD-003]
	History and Physical - SHALL include Advance Directives Section (V4) (entries optional).[CONF:AD-004]

	Discharge Summary - SHALL include Advance Directives Section (V4) (entries optional). [CONF:AD-005]
	Continuity of Care Document - SHALL include Advance Directives Section (V4) (entries optional). [CONF:AD-006]
	Care Plan - SHALL include Advance Directives Section (V4) (entries optional). [CONF:AD-007]
	Progress Note - MAY include Advance Directives Section (V4) (entries optional). [CONF:AD-008]
	Referral Note - MAY include Advance Directives Section (V4) (entries optional). [CONF:AD-009]

For the supplemental C-CDA templates defined in this IG:

	An Advance Care Planning Intervention template MAY be included in the Interventions Section, and MAY be included in the Plan of Treatment Section when documenting planned activities or in the Procedures Section when documenting completed activities. [CONF:AD-010]
	An Obligation Instruction template SHOULD be included in the Advance Directives Section, but MAY be included in the Intervention Section or a Plan of Treatment Section. [CONF:AD-011]
	A Prohibition Instruction template SHOULD be included in the Advance Directives Section, but MAY be included in the Intervention Section or a Plan of Treatment Section. [CONF:AD-012]

Background

Why were new versions of the C-CDA Advance Directive templates needed?

- As advance care planning information began to be exchanged, shared and retrieved, concern increased about the possibility that clinicians might misinterpret patient wishes in a way that could result in errors that risk patient safety or that violate patient intent.
- Information context is crucial when it comes to interpreting advance directives. Directives should always be maintained in their original form - not chopped up and stored as structured data void of the original context.
- Updates also were needed to better align with the PACIO Advance Directive Interoperability FHIR Implementation Guide which addresses the representation of structured content for all types of advance directive information.
- Advance Directives is now a Level 1 data class in the US Core Data for Interoperability (USCDI). Stronger conformance recommendations were needed to encourage implementers to advance the use and exchange of advance directive information to attain the needed levels of maturity and standardization to support interoperability at a national level.

In volume 2 of this guide, a new version of the C-CDA Advance Directive Observation template is defined to clarify that these observations do not convert patient wishes into structured data that implies a decision or an order. Structured data in the Advance Directive Observation template is used to document the type of information present in a source advance directive document where an individual has described his or her care goals and treatment preferences and priorities in the event this information becomes needed and the person is unable to communicate with care providers as treatment decisions are made. Fixing this issue was a critical need.

Additionally, new versions of the Advance Directive Organizer template and Advance Directives Section templates were defined to clarify the critical contextual meaning and purpose conveyed in these templates.

In the 2018 version of this IG, three (3) additional templates were added to provide guidance on representing advance care planning activities performed by practitioners to include patient instructions gathered by practitioners to document treatment obligations or prohibitions pertinent to the encounter that are explicitly requested by the patient or the patient's healthcare agent:

- The Advance Care Planning Intervention template is used to exchange information about planned or performed activities associated with discussing advance care plans and educating people about advance directives. It includes guidance on how to populate service event information in the header when advance care planning review or educational services are provided.
- The Obligation Instruction template is used to record when the patient or the patient's healthcare agent has instructed care providers to perform certain activities.
- The Prohibition Instruction template is used when a patient or the patient's healthcare agent has instructed care providers not to perform certain activities.

Healthcare is evolving towards the use of advance care planning to inform patient care plans and care delivery. Recent experience gained during the COVID-19 pandemic has heightened awareness of the importance of healthcare providers having access to a person's advance directive information so that a patient's wishes are taken into consideration when the patient can't communicate, healthcare agents aren't appointed or available, and care decisions must be made.

Simply put: as the awareness of the value of advance directive information has expanded for both the patients receiving care and the teams providing care, the need for better and more mature standardized information exchange guidance also has expanded.

Use Cases

For use cases describing the exchange of Content Type 2 care team authored advance directive information refer to the HL7 FHIR PACIO Advance Directive Interoperability Implementation Guide.

Audience (Intended Users of these additional optional templates)

The audience for this IG includes implementers creating CDA encounter summary and patient summary documents that include advance directive information. The IG also is relevant to system architects and developers of healthcare information technology (HIT) systems in the US Realm that exchange clinical and non-clinical data. Business analysts and policy managers also benefit from gaining a basic understanding of the advance directive information use cases addressed by the IG. Finally, Quality Reporting Agencies, Standards Development Organizations (SDOs), Payors, Providers and Patients will benefit from this IG as it explains information representation details that are valuable when designing quality measures and expanding coded vocabularies.

Prerequisite Information

Readers of this implementation guide should first read the HL7 FHIR PACIO Advance Directive Interoperability Implementation Guide. For guidance on the use of CDA to exchange, share and retrieve Type 1 (patient-authored) Advance Directive Information, readers should be familiar with the current version of the HL7 CDA® R2 Implementation Guide: Personal Advance Care Plan (PACP) Document IG. For guidance on exchanging, sharing and retrieving advance directive information for Type 3 (practitioner-authored) Advance Directive Information using CDA, readers should consult the current version HL7 CDA R2 Implementation Guide: ePOLST: Portable Medical Orders About Resuscitation and Initial Treatment.

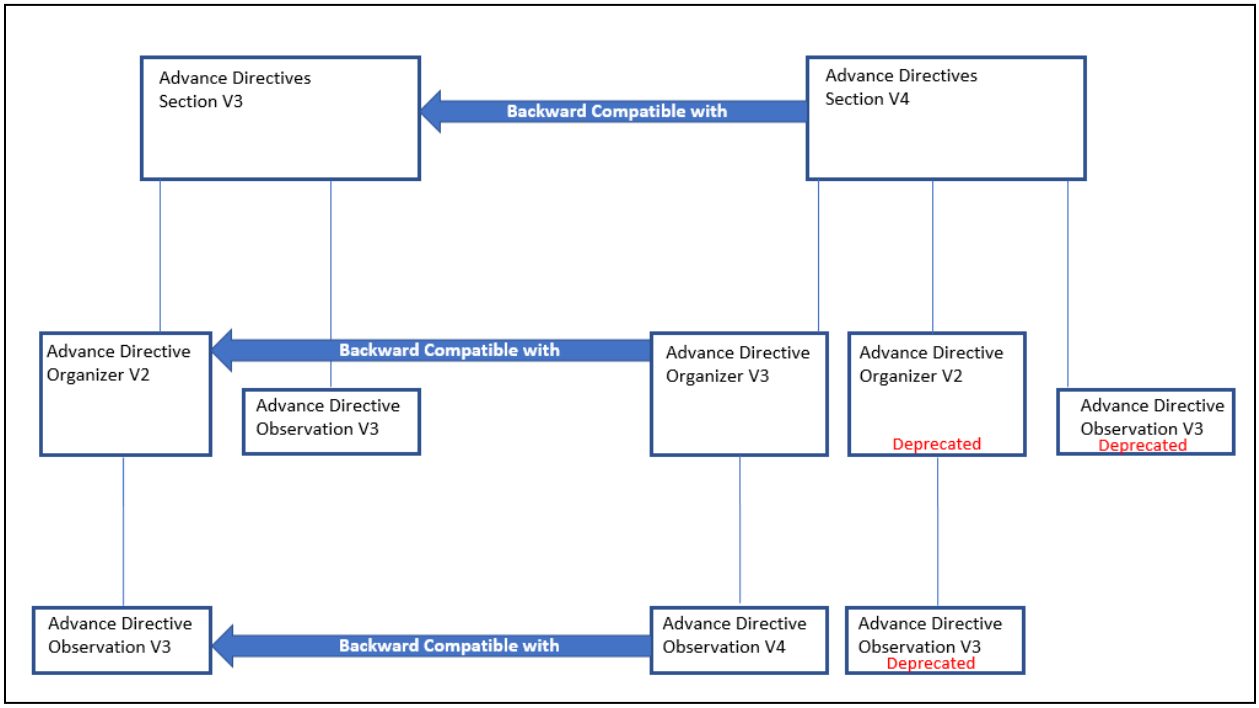
Backwards Compatibility Considerations

Backwards compatibility means a document instance that is conformant to the prior version of the template (version n-1) will also be conformant under the newer version of the template (version n).

Visual Overview

The following illustration shows the new Advance Directive template versions and their relationship to prior versions.

Figure 1: Overview of Backwards Compatibility for Advance Directive Template Revisions



See Appendix A for a constraint comparison between the new templates and prior template versions.

Appendix A – Constraint Comparison to Prior Template Versions

Advance Directive Observation (V5) template

The Advance Directive Observation (V5) template does not cause backward compatibility problems.

The Advance Directive Observation (V3) template SHALL have a code element which SHOULD be selected from a specified value set. The V5 version of the template SHALL have a code element and recommends that the code element SHOULD be populated with a concept from a different value set. This does not violate backward compatibility.

The Advance Directive Observation (V3) template SHALL have a code element with a translation @code attribute fixed to 75320-2. The V5 version includes this same requirement.

The Advance Directive Observation (V3) template SHALL have exactly one value such that if it is of type CD, the value SHALL be a SNOMED-CT concept. The V5 version of the template recommends that the value element SHOULD be of type CD and SHOULD be populated with a concept from a specified value set of SNOMED-CT concepts. This does not violate backward compatibility.

Participation comparisons are as follows:

Figure 2: Constraint Comparison for Advance Directive Observation (V3) vs. (V5)

Advance Directive Observation (V3)	Advance Directive Observation (V5)
1) SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 STATIC) (CONF:1198-8648).	1) SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 DYNAMIC) (CONF:3332-8648).
2) SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: HL7ActMood urn:oid:2.16.840.1.113883.5.1001 STATIC) (CONF:1198-8649).	2) SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: HL7ActMood urn:oid:2.16.840.1.113883.5.1001 DYNAMIC) (CONF:3332-8649).
	3) SHALL contain exactly one [1..1] templateId (CONF:3332-8655) such that it
	1) SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.48" (CONF:3332-10485).
	2) SHALL contain exactly one [1..1] @extension="2022-02-14" (CONF:3332-32496).
3) SHALL contain exactly one [1..1] templateId (CONF:1198-8655) such that it	4) MAY contain zero or one [0..1] templateId (CONF:3332-32996) such that it
1) SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.48" (CONF:1198-10485).	1) SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.48" (CONF:3332-32997).
2) SHALL contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32496).	2) SHALL contain exactly one [1..1] @extension="2015-08-01" (CONF:3332-32998).
4) SHALL contain at least one [1..*] id (CONF:1198-8654).	5) SHALL contain at least one [1..*] id (CONF:3332-8654).

Advance Directive Observation (V3)	Advance Directive Observation (V5)
5) SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet AdvanceDirectiveTypeCode urn:oid:2.16.840.1.113883.1.11.20.2 STATIC 2015-08-01 (CONF:1198-8651).	6) SHALL contain exactly one [1..1] code, which SHOULD be selected from ValueSet Advance Directives Categories urn:oid:2.16.840.1.113883.11.20.9.69.4 DYNAMIC (CONF:3332-8651).
1) This code SHALL contain exactly one [1..1] translation (CONF:1198-32842) such that it	1) This code SHALL contain exactly one [1..1] translation (CONF:3332-32842) such that it
1) SHALL contain exactly one [1..1] @code="75320-2" Advance directive (CONF:1198-32843).	1) SHALL contain exactly one [1..1] @code="75320-2" Advance Directive (CONF:3332-32843).
2) SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:1198-32844).	2) SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:3332-32844).
	3) SHALL contain exactly one [1..1] @codeSystemName="LOINC" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:3332-33061).
	7) SHALL contain exactly one [1..1] text (CONF:3332-33063).
6) SHALL contain exactly one [1..1] statusCode (CONF:1198-8652).	8) SHALL contain exactly one [1..1] statusCode (CONF:3332-8652).
1) This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: HL7ActStatus urn:oid:2.16.840.1.113883.5.14 STATIC) (CONF:1198-19082).	1) This statusCode SHALL contain exactly one [1..1] @code="completed" Completed (CodeSystem: HL7ActStatus urn:oid:2.16.840.1.113883.5.14 DYNAMIC) (CONF:3332-19082).
7) SHALL contain exactly one [1..1] effectiveTime (CONF:1198-8656).	9) SHALL contain exactly one [1..1] effectiveTime (CONF:3332-8656).
1) This effectiveTime SHALL contain exactly one [1..1] low (CONF:1198-28719).	1) This effectiveTime SHALL contain exactly one [1..1] low (CONF:3332-28719).
2) This effectiveTime SHALL contain exactly one [1..1] high (CONF:1198-15521).	2) This effectiveTime SHALL contain exactly one [1..1] high (CONF:3332-15521).
1) If the Advance Directive does not have a specified ending time, the element *SHALL* have the nullFlavor attribute set to *NA* (CONF:1198-32449).	1) If the Advance Directive does not have a specified ending time, the element *SHALL* have the nullFlavor attribute set to *NA* (CONF:3332-32449).
8) SHALL contain exactly one [1..1] value (CONF:1198-30804) such that it	10) SHALL contain exactly one [1..1] value (ValueSet: Advance Directive Content Type SCT urn:oid: 2.16.840.1.113762.1.4.1115.5 DYNAMIC) (CONF:3332-30804).

Advance Directive Observation (V3)	Advance Directive Observation (V5)
1) If type CD, then value will be SNOMED-CT 2.16.840.1.113883.6.96 (CONF:1198-32493).	1) The value element SHOULD NOT contain an @code attribute with SNOMED CT concept [225204009 | IV fluid support (procedure)] OR [304251008 | Resuscitation status (observable entity)].
9) SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:1198-32406).	11) SHOULD contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:3332-32406).
The participant "VRF" represents the clinician(s) who verified the patient advance directive observation.	The participant "VRF" represents the clinician(s) who verified the patient's advance directive.
10) SHOULD contain zero or more [0..*] participant (CONF:1198-8662) such that it	12) SHOULD contain zero or more [0..*] participant (CONF:3332-8662) such that it
1) SHALL contain exactly one [1..1] @typeCode="VRF" Verifier (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90 STATIC) (CONF:1198-8663).	1) SHALL contain exactly one [1..1] @typeCode="VRF" Verifier (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90 DYNAMIC) (CONF:3332-8663).
2) SHALL contain exactly one [1..1] templateId (CONF:1198-8664) such that it	2) SHALL contain exactly one [1..1] templateId (CONF:3332-8664) such that it
1) SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.1.58" (CONF:1198-10486).	1) SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.1.58" (CONF:3332-10486).
3) SHOULD contain zero or one [0..1] time (CONF:1198-8665).	3) SHOULD contain zero or one [0..1] time (CONF:3332-8665).
1) The data type of Observation/participant/time in a verification *SHALL* be *TS* (time stamp) (CONF:1198-8666).	1) The data type of Observation/participant/time in a verification *SHALL* be *TS* (time stamp) (CONF:3332-8666).
4) SHALL contain exactly one [1..1] participantRole (CONF:1198-8825).	4) SHALL contain exactly one [1..1] participantRole (CONF:3332-8825).
1) This participantRole SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) urn:oid:2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:1198-28446).	1) This participantRole SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Provider Taxonomy (HIPAA) urn:oid:2.16.840.1.114222.4.11.1066 DYNAMIC (CONF:3332-28446).
2) This participantRole MAY contain zero or more [0..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1198-28451).	2) This participantRole MAY contain zero or more [0..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:3332-28451).
3) This participantRole MAY contain zero or one [0..1] playingEntity (CONF:1198-28428).	3) This participantRole SHALL contain exactly one [1..1] playingEntity (CONF:3332-28428).

Advance Directive Observation (V3)	Advance Directive Observation (V5)
1) The playingEntity, if present, MAY contain zero or more [0..*] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-28454).	1) This playingEntity SHALL contain exactly one [1..1] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:3332-28454).
This custodian (CST) participant identifies a legal representative for the patient's advance directive. Examples of such individuals are called health care agents, substitute decision makers and/or health care proxies. If there is more than one legal representative, a qualifier may be used to designate the legal representative as primary or secondary.	This custodian (CST) participant identifies a legal representative for healthcare decision-making. Examples of such individuals are called health care agents, substitute decision makers and/or health care proxies. Only record a healthcare agent who is acting in that capacity and participating in care decision-making during the documented care encounter.
11) SHOULD contain zero or more [0..*] participant (CONF:1198-8667) such that it	13) SHOULD contain zero or more [0..*] participant (CONF:3332-8667) such that it
1) SHALL contain exactly one [1..1] @typeCode="CST" Custodian (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90 STATIC) (CONF:1198-8668).	1) SHALL contain exactly one [1..1] @typeCode="CST" Custodian (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90 DYNAMIC) (CONF:3332-8668).
2) SHALL contain exactly one [1..1] participantRole (CONF:1198-8669).	2) SHALL contain exactly one [1..1] participantRole (CONF:3332-8669).
1) This participantRole SHALL contain exactly one [1..1] @classCode="AGNT" Agent (CodeSystem: HL7RoleClass urn:oid:2.16.840.1.113883.5.11STATIC) (CONF:1198-8670).	1) This participantRole SHALL contain exactly one [1..1] @classCode="AGNT" Agent (CodeSystem: HL7RoleClass urn:oid:2.16.840.1.113883.5.110 DYNAMIC) (CONF:3332-8670).
2) This participantRole SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Personal And Legal Relationship Role Type urn:oid:2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:1198-28440).	2) This participantRole SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Agent or Proxy Choices urn:oid:2.16.840.1.113762.1.4.1046.35 DYNAMIC (CONF:3332-28440).
3) This participantRole SHOULD contain zero or one [0..1] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:1198-8671).	3) This participantRole SHOULD contain zero or one [0..1] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:3332-8671).
4) This participantRole SHOULD contain zero or more [0..*] telecom (CONF:1198-8672).	4) This participantRole SHOULD contain zero or more [0..*] telecom (CONF:3332-8672).
5) This participantRole SHALL contain exactly one [1..1] playingEntity (CONF:1198-8824).	5) This participantRole SHALL contain exactly one [1..1] playingEntity (CONF:3332-8824).

Advance Directive Observation (V3)	Advance Directive Observation (V5)
1) This playingEntity SHOULD contain zero or one [0..1] code, which SHOULD be selected from ValueSet Healthcare Agent Qualifier urn:oid:2.16.840.1.113883.11.20.9.51 DYNAMIC (CONF:1198-28444).	
Record the name of the agent who can provide a copy of the Advance Directive in the name element.	
2) This playingEntity SHALL contain exactly one [1..1] name (CONF:1198-8673).	1) This playingEntity SHALL contain exactly one [1..1] name (CONF:3332-8673).
12) SHOULD contain at least one [1..*] reference (CONF:1198-8692) such that it	14) SHOULD contain zero or more [0..*] reference (CONF:3332-8692) such that it
1) SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 STATIC) (CONF:1198-8694).	1) SHALL contain exactly one [1..1] @typeCode="REFR" Refers to (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 DYNAMIC) (CONF:3332-8694).
2) SHALL contain exactly one [1..1] externalDocument (CONF:1198-8693).	2) SHALL contain exactly one [1..1] externalDocument (CONF:3332-8693).
1) This externalDocument SHALL contain at least one [1..*] id (CONF:1198-8695).	1) This externalDocument SHALL contain at least one [1..*] id (CONF:3332-8695).
2) This externalDocument MAY contain zero or one [0..1] text (CONF:1198-8696).	2) This externalDocument MAY contain zero or one [0..1] text (CONF:3332-8696).
1) The text, if present, MAY contain zero or one [0..1] reference (CONF:1198-8697).	1) The text, if present, MAY contain zero or one [0..1] reference (CONF:3332-8697).
1) The URL of a referenced advance directive document *MAY* be present, and *SHALL* be represented in Observation/reference/ExternalDocument/text/reference (CONF:1198-8698).	1) The URL of a referenced advance directive document *MAY* be present, and *SHALL* be represented in Observation/reference/ExternalDocument/text/reference (CONF:3332-8698).
2) If a URL is referenced, then it *SHOULD* have a corresponding linkHTML element in narrative block (CONF:1198-8699).	2) If a URL is referenced, then it *SHOULD* have a corresponding linkHTML element in narrative block (CONF:3332-8699).

Advance Directive Organizer (V4) template

The Advance Directives Organizer (V4) template does not cause backward compatibility problems.

The Advance Directive Organizer (V2) template SHOULD have at least one author and SHALL have 1 or more components that are conformant to the Advance Directive Observation (V3) template.

The Advance Directive Organizer (V4) template SHOULD have at least one author and SHALL have 1 or more components that are conformant to the Advance Directive Observation (V5) template which in turn complies with the Advance Directive Observation (V3) template.

Advance Directives Section (V5) (entries optional and entries required)

The Advance Directives Section (V5) template does not cause backward compatibility problems.

Conformance constraints have been added to permit earlier versions of the Advance Directive entry templates, while at the same time encouraging use of the newer versions rather than the older version.

Part 2. Advance Directives Templates

1 Section

1.1 Advance Directives Section (entries optional) (V5)

`[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2022-02-14 (open)]`

`Published as part of Advance Directives - Template Revisions`

Table 1: Advance Directives Section (entries optional) (V5) Contexts

Contained By:	Contains:
	Advance Directive Organizer (V4) (optional)

This section contains information describing the patient's advance directives. The description includes the kind of advance directive source documents and the type of advance directive content included in each kind of advance directive source document. The section includes information about who verified the content available in each advance directive source document, if applicable. It also includes information about who was the acting healthcare agent, if someone was acting on behalf of the patient during the encounter or during certain periods of time during the provision of care covered by the document. It provides references to the supporting documentation, including all kinds of advance directive source documents.

This section differentiates between an "advance care plan document" and an "advance care plan order." It also distinguishes an advance directive that is a consent. Information in this section shall only include information about the person's current/relevant goals and preferences, advance directive orders, or advance directive consents.

The "entries optional" version does not require any entries. The template purpose revisions clarify the intention for the information to be included in the narrative text of the section and keep it aligned with the new version of the section that requires entries.

NOTE: This template is backward compatible with the Advance Directives Section (entries optional) (V3) template and can be used as a substitute in any document that calls for the Advance Directives Section (entries optional) (V3) template.

Table 2: Advance Directives Section (entries optional) (V5) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2022-02-14)					
templateId	1..1	SHALL		3332-7928	
@root	1..1	SHALL		3332-10376	2.16.840.1.113883.10.20.22.2.21
@extension	1..1	SHALL		3332-32497	2022-02-14
templateId	0..1	MAY		3332-33002	
@root	1..1	SHALL		3332-33003	2.16.840.1.113883.10.20.22.2.21
@extension	1..1	SHALL		3332-33004	2015-08-01
code	1..1	SHALL		3332-15340	
@code	1..1	SHALL		3332-15342	42348-3
@codeSystem	1..1	SHALL		3332-30812	urn:oid:2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		3332-7930	
text	1..1	SHALL		3332-7931	
entry	0..*	SHOULD NOT		3332-7957	
observation	1..1	SHALL		3332-15443	Advance Directive Observation (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2015-08-01
entry	0..*	SHOULD NOT		3332-32891	
organizer	1..1	SHALL		3332-32892	Advance Directive Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2015-08-01
entry	0..*	MAY		3332-33008	
organizer	1..1	SHALL		3332-33011	Advance Directive Organizer (V4) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2022-02-14

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:3332-7928) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.21" (CONF:3332-10376).

    b. **SHALL** contain exactly one [1..1] **@extension**="2022-02-14" (CONF:3332-32497).
2. **MAY** contain zero or one [0..1] **templateId** (CONF:3332-33002) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.21" (CONF:3332-33003).
    b. **SHALL** contain exactly one [1..1] **@extension**="2015-08-01" (CONF:3332-33004).
3. **SHALL** contain exactly one [1..1] **code** (CONF:3332-15340).
    a. This code **SHALL** contain exactly one [1..1] **@code**="42348-3" Advance Directives (CONF:3332-15342).
    b. This code **SHALL** contain exactly one [1..1] **@codeSystem**="2.16.840.1.113883.6.1" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:3332-30812).
4. **SHALL** contain exactly one [1..1] **title** (CONF:3332-7930).
5. **SHALL** contain exactly one [1..1] **text** (CONF:3332-7931).
6. **SHOULD NOT** contain zero or more [0..*] **entry** (CONF:3332-7957) such that it
    a. **SHALL** contain exactly one [1..1] Advance Directive Observation (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2015-08-01) (CONF:3332-15443).
7. **SHOULD NOT** contain zero or more [0..*] **entry** (CONF:3332-32891) such that it
    a. **SHALL** contain exactly one [1..1] Advance Directive Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2015-08-01) (CONF:3332-32892).
8. **MAY** contain zero or more [0..*] **entry** (CONF:3332-33008) such that it
    a. **SHALL** contain exactly one [1..1] **Advance Directive Organizer (V4)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2022-02-14) (CONF:3332-33011).

Figure 3: Advance Directives Section (entries optional) (V5)

```
<!-- ************* ADVANCE DIRECTIVES *************** -->
<component>
<section>
  <!-- *** Advance Directives section with entries NOT required *** -->
  <templateId root="2.16.840.1.113883.10.20.22.2.21" extension="2022-02-14"/>
  <templateId root="2.16.840.1.113883.10.20.22.2.21" extension="2015-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.22.2.21"/>
  <id  root="631F0E95-F055-4FA2-AF10-3AE036CAD2EC" extension="9.1"/>
  <code code="42348-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
  <title>ADVANCE DIRECTIVES</title>
  <text>
    <list>
      <item ID="ADe-01">
      <content styleCode="Bold">Review of Patient Preferences</content><br/>
      <content>Associated Encounter: Inpatient Stay (8/7/2017- 8/10/2017)
</content><br/>
      <content>(Documented by: Nancy Nightingale, RN August 07, 2017 4:30
pm)</content><br/>
      <table border="1" width="100%" >
      <thead>
        <tr>
          <th>Category of Directive:</th>
          <th>Established on:</th>
          <th>Supporting Document:</th>
          <th>Verified by:</th>
          <th>Time of Verification:</th>
        </tr>
      </thead>
      <tbody>
        <tr>
          <td>Personal Advance Care Plan</td>
          <td>August 11, 2016</td>
          <td>
             <linkHtml href="McBee-Roger-Rienman-2018-01-23-120935.pdf">PACP
Document Link</linkHtml>
          </td>
          <td>Dr. Patricia Primary </td>
          <td>(August 07, 2017 3:00 pm)</td>
        </tr>
       </tbody>
       </table>

       <table>
       <thead>
         <tr>
           <th ID="ADC">Type of Patient Preferences Available:</th>
         </tr>
         </thead>
       <tbody>
         <tr><td ID="ADCT-1">Healthcare agent appointment</td></tr>
         <tr><td ID="ADCT-2">Life support</td></tr>
         <tr><td ID="ADCT-3">Cardiopulmonary resuscitation</td></tr>
         <tr><td ID="ADCT-4">Palliative care</td></tr>
         <tr><td ID="ADCT-5">Organ donation</td></tr>
         <tr><td ID="ADCT-6">Autopsy</td></tr>
         <tr><td ID="ADCT-7">Other directives</td></tr>
       </tbody>
```

```
        </table>
        <table ID="HealthcareAgents">
        <thead>
          <tr>
            <th>Healthcare Agent Name:</th>
            <th>Contact Info:</th>
            <th>Named on date:</th>
            <th>Role:</th>
            <th>Status:</th>
          </tr>
        </thead>
        <tbody>
          <tr ID="HCA-1">
            <td>Jeff Zucker (Friend)</td>
            <td>zuckerjeff@gmail.com</td>
            <td>02/19/2011</td>
            <td>Primary Healthcare Agent</td>
            <td>Pending as of 1/23/2018 </td>
          </tr>
          ... Additional Healthcare Agents ...
       </tbody>
      </table>
     </item>
   </list>
</text>
</section>
</component>
```

1.2 Advance Directives Section (entries required) (V5)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.21.1:2022-02-14 (open)]

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Table 3: Advance Directives Section (entries required) (V5) Contexts

Contained By:	Contains:
	Advance Directive Observation (V5) (optional) Advance Directive Organizer (V4) (required)

This section contains information describing the patient's advance directives. The description includes the kind of advance directive source documents and the type of advance directive content included in each kind of advance directive source document. The section includes information about who verified the content available in each advance directive source document, if applicable. It also includes information about who was the acting healthcare agent, if someone was acting on behalf of the patient during the encounter or during certain periods of time during the provision of care covered by the document. It provides references to the supporting documentation, including all kinds of advance directive source documents.

This section differentiates between an "advance care plan document" and an "advance care plan order." It also distinguishes an advance directive that is a consent. Information in this section

includes information about the person's current/relevant goals and preferences, advance directive orders, or advance directive consents.

The "entries required" version of this section template requires one or more entries. To fulfill this requirement, the Advance Directive Organizer V4 2022-02-14 is recommended for use. For backwards compatibility, the Advance Directive Observation V3 and Advance Directive Organizer V2 templates also are supported.

When asserting conformance with the Advance Directives Section (entries required) template, but there is no advance directive information present in the system to be included for exchange, the NI nullFlavor can be used at the section level.

NOTE: This template is backward compatible with the Advance Directives Section (entries required) (V3) template and can be used as a substitute in an any document that calls for the Advance Directives Section (entries required) (V3) template or the Advance Directives Section (entries optional) (V3) template.

Table 4: Advance Directives Section (entries required) (V5) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21.1:2022-02-14)					
@nullFlavor	0..1	MAY		3332-32800	urn:oid:2.16.840.1.113883.5.1008 (HL7NullFlavor) = NI
templateId	1..1	SHALL		3332-30227	
@root	1..1	SHALL		3332-30228	2.16.840.1.113883.10.20.22.2.21.1
@extension	1..1	SHALL		3332-32512	2022-02-14
templateId	0..1	MAY		3332-33005	
@root	1..1	SHALL		3332-33006	2.16.840.1.113883.10.20.22.2.21.1
@extension	1..1	SHALL		3332-33007	2015-08-01
code	1..1	SHALL		3332-32929	
@code	1..1	SHALL		3332-32930	42348-3
@codeSystem	1..1	SHALL		3332-32931	urn:oid:2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
title	1..1	SHALL		3332-32932	
text	1..1	SHALL		3332-32933	
entry	1..*	SHALL		3332-30235	

organizer	1..1	SHALL		3332-32420	Advance Directive Organizer (V4) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2022-02-14
entry	0..*	MAY		3332-33012	
observation	1..1	SHALL		3332-33071	Advance Directive Observation (V5) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2022-02-14
entry	0..*	SHOULD NOT		3332-33067	
observation	1..1	SHALL		3332-33068	Advance Directive Observation (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2015-08-01
entry	0..*	SHOULD NOT		3332-33069	
organizer	1..1	SHALL		3332-33070	Advance Directive Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2015-08-01

1. Conforms to Advance Directives Section (entries optional) (V3) template `(identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2015-08-01)`.
2. **MAY** contain zero or one [0..1] **`@nullFlavor`**="`NI`" No information (CodeSystem: `HL7NullFlavor urn:oid:2.16.840.1.113883.5.1008`) (CONF:3332-32800).
3. **SHALL** contain exactly one [1..1] **`templateId`** (CONF:3332-30227) such that it
    a. **SHALL** contain exactly one [1..1] **`@root`**="`2.16.840.1.113883.10.20.22.2.21.1`" (CONF:3332-30228).
    b. **SHALL** contain exactly one [1..1] **`@extension`**="`2022-02-14`" (CONF:3332-32512).
4. **MAY** contain zero or one [0..1] **`templateId`** (CONF:3332-33005) such that it
    a. **SHALL** contain exactly one [1..1] **`@root`**="`2.16.840.1.113883.10.20.22.2.21.1`" (CONF:3332-33006).
    b. **SHALL** contain exactly one [1..1] **`@extension`**="`2015-08-01`" (CONF:3332-33007).
5. **SHALL** contain exactly one [1..1] **`code`** (CONF:3332-32929).
    a. This code **SHALL** contain exactly one [1..1] **`@code`**="`42348-3`" Advance Directives (CONF:3332-32930).
    b. This code **SHALL** contain exactly one [1..1] **`@codeSystem`**="`2.16.840.1.113883.6.1`" (CodeSystem: `LOINC urn:oid:2.16.840.1.113883.6.1`) (CONF:3332-32931).
6. **SHALL** contain exactly one [1..1] **`title`** (CONF:3332-32932).
7. **SHALL** contain exactly one [1..1] **`text`** (CONF:3332-32933).
8. **SHALL** contain at least one [1..*] **`entry`** (CONF:3332-30235) such that it

a. **SHALL** contain exactly one [1..1] **Advance Directive Organizer (V4)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2022-02-14) (CONF:3332-32420).

9. **MAY** contain zero or more [0..*] **entry** (CONF:3332-33012) such that it
    a. **SHALL** contain exactly one [1..1] **Advance Directive Observation (V5)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2022-02-14) (CONF:3332-33071).
10. **SHOULD NOT** contain zero or more [0..*] **entry** (CONF:3332-33067) such that it
    a. **SHALL** contain exactly one [1..1] Advance Directive Observation (V3) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2015-08-01) (CONF:3332-33068).
11. **SHOULD NOT** contain zero or more [0..*] **entry** (CONF:3332-33069) such that it
    a. **SHALL** contain exactly one [1..1] Advance Directive Organizer (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2015-08-01) (CONF:3332-33070).

Figure 4: Advance Directives Section (entries required) (V5)

```
<!-- ************* ADVANCE DIRECTIVES *************** -->
<component>
<section>
  <!-- *** Advance Directives section with entries required *** -->
  <templateId root="2.16.840.1.113883.10.20.22.2.21.1" extension="2022-02-14"/>
  <templateId root="2.16.840.1.113883.10.20.22.2.21.1" extension="2015-08-01"/>
  <templateId root="2.16.840.1.113883.10.20.22.2.21"/>
  <id  root="631F0E95-F055-4FA2-AF10-3AE036CAD2EC" extension="9.1"/>
  <code code="42348-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
  <title>ADVANCE DIRECTIVES</title>
  <text>
    <list>
      <item ID="ADe-01">
      <content styleCode="Bold">Review of Patient Preferences</content><br/>
      <content>Associated Encounter: Inpatient Stay (8/7/2017- 8/10/2017)
</content><br/>
      <content>(Documented by: Nancy Nightingale, RN August 07, 2017 4:30
pm)</content><br/>
      <table border="1" width="100%" >
      <thead>
        <tr>
          <th>Category of Directive:</th>
          <th>Established on:</th>
          <th>Supporting Document:</th>
          <th>Verified by:</th>
          <th>Time of Verification:</th>
        </tr>
      </thead>
      <tbody>
        <tr>
          <td>Personal Advance Care Plan</td>
          <td>August 11, 2016</td>
          <td>
             <linkHtml href="McBee-Roger-Rienman-2018-01-23-120935.pdf">PACP
Document Link</linkHtml>
          </td>
          <td>Dr. Patricia Primary </td>
          <td>(August 07, 2017 3:00 pm)</td>
        </tr>
       </tbody>
       </table>

       <table>
       <thead>
         <tr>
           <th ID="ADC">Type of Patient Preferences Available:</th>
         </tr>
         </thead>
       <tbody>
         <tr><td ID="ADCT-1">Healthcare agent appointment</td></tr>
         <tr><td ID="ADCT-2">Life support</td></tr>
         <tr><td ID="ADCT-3">Cardiopulmonary resuscitation</td></tr>
         <tr><td ID="ADCT-4">Palliative care</td></tr>
         <tr><td ID="ADCT-5">Organ donation</td></tr>
         <tr><td ID="ADCT-6">Autopsy</td></tr>
         <tr><td ID="ADCT-7">Other directives</td></tr>
       </tbody>
```

```
        </table>
        <table ID="HealthcareAgents">
        <thead>
          <tr>
            <th>Healthcare Agent Name:</th>
            <th>Contact Info:</th>
            <th>Named on date:</th>
            <th>Role:</th>
            <th>Status:</th>
          </tr>
        </thead>
        <tbody>
          <tr ID="HCA-1">
            <td>Jeff Zucker (Friend)</td>
            <td>zuckerjeff@gmail.com</td>
            <td>02/19/2011</td>
            <td>Primary Healthcare Agent</td>
            <td>Pending as of 1/23/2018 </td>
          </tr>
          ... Additional Healthcare Agents ...
       </tbody>
      </table>
    </item>
  </list>
</text>
...
<entry>
...
</entry>
</section>
</component>
```

Figure 5: Advance Directives Section (entries required) (V5) No Information

```
<section nullFlavor="NI">
    <!-- conforms to Advance Directives section with entries optional -->
    <templateId root="2.16.840.1.113883.10.20.22.2.21" extension="2022-02-14"/>
    <!-- conforms to Advance Directives section with entries required -->
    <templateId root="2.16.840.1.113883.10.20.22.2.6.1" extension="2022-02-14"/>
    <code code="42348-3" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Advance directives"/>
    <title>ADVANCE DIRECTIVES</title>
    <text>No Information</text>
</section>
```

2 Entry

2.1 Advance Care Planning Intervention (V1)

[procedure: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.204:2017-05-01 (open)]

Published as part of Advance Directives - Template Revisions

The Advance Care Planning Intervention template is used to record a planned intervention that will involve reviewing and verifying a person's advance directives, or will involve educating and supporting a person on establishing or modifying his or her advance directives. It also can be used to record when the activity of reviewing and verifying a person's directives has been completed or when educating and supporting a person to establish or update his or her advance directives has been completed.

The Advance Care Planning Intervention template differs from the Advance Directive Observation template. Advance Care Planning Intervention template is used to document interactions (such as discussions and education) with the patient about advance directives and advance care planning. Advance Directive Observation template is used to record that a person's advance directive document has been accessed and reviewed.
Concepts from the Advance Care Planning Services value set can be used in the code element of the documentationOf/serviceEvent in the header to indicate when advance care planning services have been performed.

In a Care Plan Document, this entry can be used in the Interventions Section. In a CCD, it can be used in the Plan of Treatment section when documenting planned activities or in the Procedures Section when documenting completed activities.

This template uses moodCode to document temporal nuances of the information. The chart below describes available moodCodes, when to use each, and the meaning of effectiveTime in each case.

moodCode	moodCode Meaning	Example Usage Meaning of effectiveTime
APT	Appointment	Use when the advance care planning activity is scheduled. The date/time of the scheduled activity. (TS)
ARQ	Appointment Request	Use when an appointment to perform the advance care planning activity has been requested. Use TS for a specific requested date/time. Use TS_IVL for a request for an appointment within a time range. The date/time of the requested appointment. (TS or TS_IVL)
INT	Intent	Use when advance care planning activity is intended to happen during a range of time.

moodCode	moodCode Meaning	Example Usage Meaning of effectiveTime
		The date/time when the request was made. (TS_IVL)
PRMS	Promise	Use when advance care planning activity is promised to happen during a range of time. The date/time when the request was made. (TS_IVL)
PRP	Proposal	Use when advance care planning activity is proposed to happen during a range of time. The date/time when the request was made. (TS_IVL)
RQO	Request	Use when advance care planning activity has been requested. Use TS for a specific requested date/time. Use TS_IVL for a request for an appointment within a time range. The date/time of the requested activity will be performed. (TS or TS_IVL)
EVN	Event	Use when advance care planning activity has been performed during a range of time or at a specified time. When indicating a single timestamp, use effectiveTime/low to indicate the start time of the activity, or use effectiveTime/high to indicate the end time of the activity The date/time when the request was made. (TS or TS_IVL)

The author/time indicates the point in time when this temporal information was documented.

Table 5: Advance Care Planning Intervention (V1) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
procedure (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.204:2017-05-01)					
@classCode	1..1	SHALL		3332-32991	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass) = PROC
@moodCode	1..1	SHALL		3332-32995	urn:oid:2.16.840.1.113883.11.20.9.69 .6 (Planned or Completed moodCode)
templateId	1..1	SHALL		3332-32946	
@root	1..1	SHALL		3332-32965	2.16.840.1.113883.10.20.22.4.204
@extension	1..1	SHALL		3332-32966	2017-05-01
id	1..*	SHALL		3332-32993	
code	1..1	SHALL		3332-32947	urn:oid:2.16.840.1.113883.11.20.9.69 .1.3 (Advance Care Planning Services Grouping)
text	1..1	SHALL		3332-33062	
statusCode	1..1	SHALL		3332-32949	
@code	1..1	SHALL		3332-32969	urn:oid:2.16.840.1.113883.11.20.9.22 (ProcedureAct statusCode)
effectiveTime	1..1	SHALL		3332-32950	
low	1..1	SHALL		3332-32971	
high	0..1	MAY		3332-32951	
performer	0..*	SHOULD		3332-33014	
time	0..1	SHOULD		3332-33015	
assignedEntity	1..1	SHALL		3332-33064	
assignedPerson	1..1	SHALL		3332-33065	
name	1..1	SHALL		3332-33066	
author	0..*	SHOULD		3332-32994	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4 .119

1. **SHALL** contain exactly one [1..1] **@classCode**="PROC" Procedure (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 **STATIC**) (CONF:3332-32991).

2. **SHALL** contain exactly one [1..1] **@moodCode** (ValueSet: **Planned or Completed moodCode** urn:oid:2.16.840.1.113883.11.20.9.69.6) (CONF:3332-32995).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:3332-32946) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.204" (CONF:3332-32965).
    b. **SHALL** contain exactly one [1..1] **@extension**="2017-05-01" (CONF:3332-32966).
4. **SHALL** contain at least one [1..*] **id** (CONF:3332-32993).
5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **Advance Care Planning Services Grouping** urn:oid:2.16.840.1.113883.11.20.9.69.1.3 **DYNAMIC** (CONF:3332-32947).
6. **SHALL** contain exactly one [1..1] **text** (CONF:3332-33062).
7. **SHALL** contain exactly one [1..1] **statusCode** (CONF:3332-32949).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code** (ValueSet: **ProcedureAct statusCode** urn:oid:2.16.840.1.113883.11.20.9.22 **DYNAMIC**) (CONF:3332-32969).
8. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:3332-32950).

Record the effectiveTime information for acts in all moodCodes except EVN in the effectiveTime/low. Record the time of the act in moodCode EVN in effectiveTime/high (completion of planned intervention).

    a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:3332-32971).

Record the time of the act in moodCode EVN in effectiveTime/high (completion of planned intervention). Note: Record the effectiveTime information for acts in all moodCodes except EVN in the effectiveTime/low.

    b. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:3332-32951).

The performer records the person who is intended to complete the planned action, or the person who completed the action when moodCode=EVN. The performer/time element records when the performer is expected to complete the action, or when the performer completed the action if moodCode=EVN.

9. **SHOULD** contain zero or more [0..*] **performer** (CONF:3332-33014) such that it
    a. **SHOULD** contain zero or one [0..1] **time** (CONF:3332-33015).
    b. **SHALL** contain exactly one [1..1] **assignedEntity** (CONF:3332-33064).
        i. This assignedEntity **SHALL** contain exactly one [1..1] **assignedPerson** (CONF:3332-33065).
            1. This assignedPerson **SHALL** contain exactly one [1..1] **name** (CONF:3332-33066).
10. **SHOULD** contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:3332-32994).

Figure 6: Advance Care Planning Intervention (V1) - For a planned advance care planning activity

```
<!-- This example could be used in the Plan of Treatment Section in a CCD or in the
Intervention Section of a Care Plan Document. -->
<!-- This is an example of a planned activity that has not been completed yet.-->
<!-- In the section.text-->
<text>
...
<table border="1" width="100%">
  <thead>
    <tr>
      <th>Planned Care:</th>
      <th>Status:</th>
      <th>Date of Service:</th>
      <th>Service Provider:</th>
      <th>Planned As of (by):</th>
    </tr>
  </thead>
  <tbody>
    <tr ID="ACPIntervention-01">
      <td ID="ACPInt-01-care">Advance Care Planning Consultation</td>
      <td styleCode="Italic">Scheduled</td>
      <td>Sept 15, 2017 2:00pm</td>
      <td>Patricia Primary, MD</td>
      <td>August 15, 2017 10:30am (Patricia Primary, MD)</td>
    </tr>
  </tbody>
</table>
...
<text>
<!-- In the corresponding machine processable entry-->
<entry>
  <!-- Advance Care Planning Intervention (V1) -->
  <procedure classCode="PROC" moodCode="APT">
    <templateId root="2.16.840.1.113883.10.20.22.4.204" extension="2017-05-01"/>
    <id root="9a6d1bac-17d3-4195-89c4-1121bc809b5a"/>
    <code code="713662007" displayName="Discussion about advance care planning
(procedure)"
          codeSystem="2.16.840.1.113883.6.96"
          codeSystemName="SNOMED CT">
      <originalText><reference value="#ACPInt-01-care"></reference></originalText>
    </code>
    <text><reference value="#ACPIntervention-01"></reference></text>
    <statusCode code="active"/>
    <effectiveTime value="20170915140000-0500"/>
    <performer>
      <assignedEntity>
        <!-- This id points back to a participant in the header -->
        <id extension="555555555" root="2.16.840.1.113883.4.6"/>
        <code code="207QA0505X" displayName="Adult Medicine"
              codeSystem="2.16.840.1.113883.6.101"
              codeSystemName="Healthcare Provider Taxonomy (HIPAA)"/>
        <assignedPerson>
          <name>Patricia Primary, MD</name>
        </assignedPerson>
      </assignedEntity>
    </performer>
    <author typeCode="AUT">
      <templateId root="2.16.840.1.113883.10.20.22.4.119"/>
```

```
      <time value="201708151030-0500"/>
      <assignedAuthor>
        <!-- This id points back to a participant in the header -->
        <id extension="555555555" root="2.16.840.1.113883.4.6"/>
        <code code="207QA0505X" displayName="Adult Medicine"
            codeSystem="2.16.840.1.113883.6.101"
            codeSystemName="Healthcare Provider Taxonomy (HIPAA)"/>
        <assignedPerson>
          <name>Patricia Primary, MD</name>
        </assignedPerson>
      </assignedAuthor>
    </author>
</procedure>
</entry>
```

Figure 7: Advance Care Planning Intervention (V1) - For a completed advance care planning activity

```
<!-- This example could be used in the Procedure Section in a CCD or in the
Intervention Section of a Care Plan Document. -->
<!-- This is an example of a completed activity/intervention.-->
<!-- In the section.text-->
<text>
...
<table border="1" width="100%">
  <thead>
    <tr>
      <th>Procedure:</th>
      <th>Status:</th>
      <th>Date of Service:</th>
      <th>Service Provider:</th>
      <th>Documented by (time):</th>
    </tr>
  </thead>
  <tbody>
    <tr ID="ACPActivity-01">
      <td ID="ACPAct-01-care">Advance Care Planning Consultation</td>
      <td styleCode="Italic">Completed</td>
      <td>August 15, 2017 10:00am</td>
      <td>Patricia Primary, MD</td>
      <td>Patricia Primary, MD (August 15, 2017 10:30am )</td>
    </tr>
  </tbody>
</table>
...
<text>
<!-- In the corresponding machine processable entry-->
<entry>
  <!-- Advance Care Planning Intervention (V1) That has been completed-->
  <procedure classCode="PROC" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.204" extension="2017-05-01"/>
    <id root="9a6d1bac-17d3-4195-89c4-1121bc809b5a"/>
    <code code="713662007" displayName="Discussion about advance care planning
(procedure)"
          codeSystem="2.16.840.1.113883.6.96"
          codeSystemName="SNOMED CT">
      <originalText><reference value="#ACPInt-01-care"></reference></originalText>
    </code>
    <text><reference value="#ACPIntervention-01"></reference></text>
    <statusCode code="completed"/>
    <effectiveTime value="20170815100000-0500"/>
    <performer>
      <assignedEntity>
        <!-- This id points back to a participant in the header -->
        <id extension="555555555" root="2.16.840.1.113883.4.6"/>
        <code code="207QA0505X" displayName="Adult Medicine"
              codeSystem="2.16.840.1.113883.6.101"
              codeSystemName="Healthcare Provider Taxonomy (HIPAA)"/>
        <assignedPerson>
          <name>Patricia Primary, MD</name>
        </assignedPerson>
      </assignedEntity>
    </performer>
    <author typeCode="AUT">
      <templateId root="2.16.840.1.113883.10.20.22.4.119"/>
```

```
      <time value="201708151030-0500"/>
      <assignedAuthor>
        <!-- This id points back to a participant in the header -->
        <id extension="555555555" root="2.16.840.1.113883.4.6"/>
        <code code="207QA0505X" displayName="Adult Medicine"
            codeSystem="2.16.840.1.113883.6.101"
            codeSystemName="Healthcare Provider Taxonomy (HIPAA)"/>
        <assignedPerson>
          <name>Patricia Primary, MD</name>
        </assignedPerson>
      </assignedAuthor>
    </author>
</procedure>
</entry>
```

2.2 Advance Directive Observation (V5)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2022-02-14 (open)]

Published as part of Advance Directives - Template Revisions

Table 6: Advance Directive Observation (V5) Contexts

Contained By:	Contains:
Advance Directives Section (entries required) (V5) (optional) Advance Directive Organizer (V4) (required)	

An Advance Directive Observation template is used to record information about a document authored by the person and containing goals, preferences, and priorities for care. The observation records that the document was available and may have been reviewed (verified). It records the kind (category) of advance directive document, where the document can be accessed, who verified it, and the type of content that was determined to be present. When a person has more than one advance directive document, each document is recorded using an Advance Directive Observation template. A set of Advance Directive Observations are grouped together using an Advance Directive Organizer.

An Advance Directive Observation template is not used to record information about portable medical orders, such as Medical Orders for Life Sustaining Treatments (MOLST), Physician Orders for Life Sustaining Treatments (POLST), or out-of-hospital Do Not Resuscitate (DNR) Orders. Portable medical order documents are authored by physicians, not patients. They document medical treatment intervention decisions that have been made rather than goals, preferences and priorities that a patient intends to be used as guidance when making care decisions.

The Advance Directive Observation template differs from the Advance Care Planning Intervention template. The Advance Directive Observation template is used to record that a person's advance directive document has been accessed and reviewed. The Advance Care

Planning Intervention template is used to document interactions, such as discussions or education, with the patient about advance care planning and personal advance care plans.

The categories of advance directives source documents could include, but are not limited to, the following:
- Personal advance care plan
- Living Will
- Durable Healthcare (Medical) Power of Attorney

Note: Under common law, a "power of attorney" was automatically revoked by the incompetency or incapacity of the principal, so the common law power of attorney was not useful as a planning for incapacity. Accordingly, states adopted "durable" power of attorney statutes allowing an agent to continue to act as empowered by a power of attorney even after the principal became disabled, incompetent or incapacitated.

The types of content in an advance directive could include, but are not limited to:
- Healthcare agent consent
- Antibiotics administration preference
- Artificial nutrition and hydration administration preference
- Intubation and Ventilation procedure preference
- Resuscitation procedure preference
- Diagnostic Testing procedure preference
- Preferences relating to palliative care
- Preferences relating to hospice care at the end of life
- Organ donation preference
- Autopsy procedure preference
- Burial preference
- Care preference that is general in nature which the patient wants care providers to take into consideration
- Information about a personal goal, such as seeing a grandchild born, attending a child's wedding, finding care for a beloved pet, or dying in a certain place.

Examples:
A person may have a durable healthcare power of attorney that appoints a Healthcare Power of Attorney. It may indicate that the person's spouse has been established as the primary healthcare agent, and the person's daughter as the first alternative healthcare agent. If the spouse was deceased, or was unavailable at the time, or unwilling to act as healthcare agent during the encounter being documented, then the person's daughter would be identified as the acting healthcare agent at that time. In this example, "personal advance care plan" is the category of advance directive and "Healthcare Agent" is the type of advance directive content that is present. In this example, "durable healthcare power of attorney" is the category of advance directive and "Healthcare agent" is the type of advance directive content that is present.

A personal advance care plan may contain information about a person's treatment preferences regarding resuscitation. In this example, "personal advance care plan" is the category of advance directive and "Resuscitation" is the type of advance directive content that is present.

The author of the Advance Directive Observation is the person documenting that the directives were reviewed and verified. The verifier is the person who read the document and verified the advance directive information. The role of verifier and the role of author need not be fulfilled by the same person, so each role is documented separately. However, the author and the verifier often will be the same person. This template supports Context Conduction. The author of the organizer can be assumed to be the author of the Advance Directive Observations within the organizer unless explicitly overridden an observation. When author identity confidence is high, implementers should explicitly assert conformance to the Provenance Author Participation template.

When an Advance Directive Observation template indicates that the advance directives include healthcare agent appointment information, each healthcare agent can be included in a participation with @typeCode=”CST”.

If the participation context (e.g. provenance) for an Advance Directive Observation is not established for the observation, then the participations for the encompassing Advance Directive Organizer apply to the observation.

Advance directives are effective over a range of time. The effectiveTime/low tells when they went into effect (or will go into effect) and the high tells when they ceased or will cease to be in effect. If the starting effective time is not known, effectiveTime/low is UNK, but this would still be considered "Active". If effectiveTime/high contains a value of "NA" or it is not valued, the advance directive remains active until some action is taken to make it inactive. (Explicit use of nullFlavor="NA" is the preferred approach for indicating an Advance Directive that is not time bounded.) That action may update the existing information with an effectiveTime/high or it may replace the open-ended entry with a new entry that includes the effectiveTime/high information. An advance directive is active so long as the effectiveTime/high has not been passed.

Note: This template is backward compatible with the Advance Directive Observation (V3) template and can be used in place of the Advance Directive Observation (V3) template.

Table 7: Advance Directive Observation (V5) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
observation (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2022-02-14)					
@classCode	1..1	SHALL		3332-8648	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass) = OBS
@moodCode	1..1	SHALL		3332-8649	urn:oid:2.16.840.1.113883.5.1001 (HL7ActMood) = EVN
templateId	1..1	SHALL		3332-8655	
@root	1..1	SHALL		3332-10485	2.16.840.1.113883.10.20.22.4.48
@extension	1..1	SHALL		3332-32496	2022-02-14
templateId	0..1	MAY		3332-32996	

@root	1..1	SHALL		3332-32997	2.16.840.1.113883.10.20.22.4.48
@extension	1..1	SHALL		3332-32998	2015-08-01
id	1..*	SHALL		3332-8654	
code	1..1	SHALL		3332-8651	urn:oid:2.16.840.1.113883.11.20.9.69 .4 (Advance Directives Categories)
translation	1..1	SHALL		3332-32842	
@code	1..1	SHALL		3332-32843	75320-2
@codeSystem	1..1	SHALL		3332-32844	urn:oid:2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1
@codeSystemName	1..1	SHALL		3332-33061	urn:oid:2.16.840.1.113883.6.1 (LOINC) = LOINC
text	1..1	SHALL		3332-33063	
statusCode	1..1	SHALL		3332-8652	
@code	1..1	SHALL		3332-19082	urn:oid:2.16.840.1.113883.5.14 (HL7ActStatus) = completed
effectiveTime	1..1	SHALL		3332-8656	
low	1..1	SHALL		3332-28719	
high	1..1	SHALL		3332-15521	
value	1..1	SHALL		3332-30804	urn:oid:2.16.840.1.113762.1.4.1115.5 (Advance Directive Content Type SCT)
author	0..*	SHOULD		3332-32406	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4 .119
participant	0..*	SHOULD		3332-8662	
@typeCode	1..1	SHALL		3332-8663	urn:oid:2.16.840.1.113883.5.90 (HL7ParticipationType) = VRF
templateId	1..1	SHALL		3332-8664	
@root	1..1	SHALL		3332-10486	2.16.840.1.113883.10.20.1.58
time	0..1	SHOULD		3332-8665	
participantRole	1..1	SHALL		3332-8825	
code	0..1	SHOULD		3332-28446	urn:oid:2.16.840.1.114222.4.11.1066 (Healthcare Provider Taxonomy)

addr	0..*	MAY		3332-28451	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
playingEntity	1..1	SHALL		3332-28428	
name	1..1	SHALL		3332-28454	US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1
participant	0..*	SHOULD		3332-8667	
@typeCode	1..1	SHALL		3332-8668	urn:oid:2.16.840.1.113883.5.90 (HL7ParticipationType) = CST
participantRole	1..1	SHALL		3332-8669	
@classCode	1..1	SHALL		3332-8670	urn:oid:2.16.840.1.113883.5.110 (HL7RoleClass) = AGNT
code	0..1	SHOULD		3332-28440	urn:oid:2.16.840.1.113762.1.4.1046.35 (Healthcare Agent or Proxy Choices)
addr	0..1	SHOULD		3332-8671	US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2
telecom	0..*	SHOULD		3332-8672	
playingEntity	1..1	SHALL		3332-8824	
name	1..1	SHALL		3332-8673	
reference	0..*	SHOULD		3332-8692	
@typeCode	1..1	SHALL		3332-8694	urn:oid:2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR
externalDocument	1..1	SHALL		3332-8693	
id	1..*	SHALL		3332-8695	
text	0..1	MAY		3332-8696	
reference	0..1	MAY		3332-8697	

1. **SHALL** contain exactly one [1..1] **@classCode**="OBS" Observation (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 **STATIC**) (CONF:3332-8648).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: HL7ActMood urn:oid:2.16.840.1.113883.5.1001 **STATIC**) (CONF:3332-8649).
3. **SHALL** contain exactly one [1..1] **templateId** (CONF:3332-8655) such that it

a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.48" (CONF:3332-10485).
b. **SHALL** contain exactly one [1..1] **@extension**="2022-02-14" (CONF:3332-32496).

4. **MAY** contain zero or one [0..1] **templateId** (CONF:3332-32996) such that it
   a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.48" (CONF:3332-32997).
   b. **SHALL** contain exactly one [1..1] **@extension**="2015-08-01" (CONF:3332-32998).
5. **SHALL** contain at least one [1..*] **id** (CONF:3332-8654).
6. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **Advance Directives Categories** urn:oid:2.16.840.1.113883.11.20.9.69.4 **DYNAMIC** (CONF:3332-8651).
   a. This code **SHALL** contain exactly one [1..1] **translation** (CONF:3332-32842) such that it
      i. **SHALL** contain exactly one [1..1] **@code**="75320-2" Advance Directive (CONF:3332-32843).
      ii. **SHALL** contain exactly one [1..1] **@codeSystem**="2.16.840.1.113883.6.1" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:3332-32844).
      iii. **SHALL** contain exactly one [1..1] **@codeSystemName**="LOINC" (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1) (CONF:3332-33061).
7. **SHALL** contain exactly one [1..1] **text** (CONF:3332-33063).
8. **SHALL** contain exactly one [1..1] **statusCode** (CONF:3332-8652).
   a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" Completed (CodeSystem: HL7ActStatus urn:oid:2.16.840.1.113883.5.14 **STATIC**) (CONF:3332-19082).
9. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:3332-8656).
   a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:3332-28719).
   b. This effectiveTime **SHALL** contain exactly one [1..1] **high** (CONF:3332-15521).
      i. If the Advance Directive does not have a specified ending time, the <high> element **SHALL** have the nullFlavor attribute set to *NA* (CONF:3332-32449).
10. **SHALL** contain exactly one [1..1] **value** (ValueSet: **Advance Directive Content Type SCT** urn:oid:2.16.840.1.113762.1.4.1115.5 **DYNAMIC**) (CONF:3332-30804).
11. **SHOULD** contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:3332-32406).

The participant "VRF" represents the clinician(s) who verified the patient's advance directive.

12. **SHOULD** contain zero or more [0..*] **participant** (CONF:3332-8662) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="VRF" Verifier (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90 **STATIC**) (CONF:3332-8663).

b. **SHALL** contain exactly one [1..1] **templateId** (CONF:3332-8664) such that it
    i. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.1.58" (CONF:3332-10486).
c. **SHOULD** contain zero or one [0..1] **time** (CONF:3332-8665).
    i. The data type of Observation/participant/time in a verification **SHALL** be *TS* (time stamp) (CONF:3332-8666).
d. **SHALL** contain exactly one [1..1] **participantRole** (CONF:3332-8825).
    i. This participantRole **SHOULD** contain zero or one [0..1] **code**, which **SHOULD** be selected from ValueSet **Healthcare Provider Taxonomy** urn:oid:2.16.840.1.114222.4.11.1066 **DYNAMIC** (CONF:3332-28446).
    ii. This participantRole **MAY** contain zero or more [0..*] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:3332-28451).
    iii. This participantRole **SHALL** contain exactly one [1..1] **playingEntity** (CONF:3332-28428).
        1. This playingEntity **SHALL** contain exactly one [1..1] US Realm Person Name (PN.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:3332-28454).

This custodian (CST) participant identifies a legal representative for healthcare decision-making. Examples of such individuals are called health care agents, substitute decision makers and/or health care proxies. Only record a healthcare agent who is acting in that capacity and participating in care decision-making during the documented care encounter.

13. **SHOULD** contain zero or more [0..*] **participant** (CONF:3332-8667) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="CST" Custodian (CodeSystem: HL7ParticipationType urn:oid:2.16.840.1.113883.5.90 **STATIC**) (CONF:3332-8668).
    b. **SHALL** contain exactly one [1..1] **participantRole** (CONF:3332-8669).
        i. This participantRole **SHALL** contain exactly one [1..1] **@classCode**="AGNT" Agent (CodeSystem: HL7RoleClass urn:oid:2.16.840.1.113883.5.110 **STATIC**) (CONF:3332-8670).
        ii. This participantRole **SHOULD** contain zero or one [0..1] **code**, which **SHOULD** be selected from ValueSet **Healthcare Agent or Proxy Choices** urn:oid:2.16.840.1.113762.1.4.1046.35 **DYNAMIC** (CONF:3332-28440).
        iii. This participantRole **SHOULD** contain zero or one [0..1] US Realm Address (AD.US.FIELDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) (CONF:3332-8671).
        iv. This participantRole **SHOULD** contain zero or more [0..*] **telecom** (CONF:3332-8672).
        v. This participantRole **SHALL** contain exactly one [1..1] **playingEntity** (CONF:3332-8824).

The name of the healthcare agent.

1. This playingEntity **SHALL** contain exactly one [1..1] **name** (CONF:3332-8673).

14. **SHOULD** contain zero or more [0..*] **reference** (CONF:3332-8692) such that it
    a. **SHALL** contain exactly one [1..1] **@typeCode**="REFR" Refers to (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 **STATIC**) (CONF:3332-8694).
    b. **SHALL** contain exactly one [1..1] **externalDocument** (CONF:3332-8693).
        i. This externalDocument **SHALL** contain at least one [1..*] **id** (CONF:3332-8695).
        ii. This externalDocument **MAY** contain zero or one [0..1] **text** (CONF:3332-8696).
            1. The text, if present, **MAY** contain zero or one [0..1] **reference** (CONF:3332-8697).
                a. The URL of a referenced advance directive document **MAY** be present, and **SHALL** be represented in Observation/reference/ExternalDocument/text/reference (CONF:3332-8698).
                b. If a URL is referenced, then it **SHOULD** have a corresponding linkHTML element in narrative block (CONF:3332-8699).

Figure 8: Advance Directive Observation (V5) Example

```
<!-- ** Advance Directive Observation (V5) ** -->
<!-- Component content regarding Healthcare Agent Appointment -->
<observation classCode="OBS" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.22.4.48" extension="2022-02-14"/>
  <templateId root="2.16.840.1.113883.10.20.22.4.48" extension="2015-08-01"/> <!--
This template can be omitted. Only shown for backward compatibility -->
  <id  root="631F0E95-F055-4FA2-AF10-3AE036CAD2EC" extension="10.1.1.1"/>
  <!-- Code tells the type of AD content and translation is fixed to 75320-2 for
backwards compatibility. -->
  <code code="75773-2"
        displayName="Personal goals, preferences, and priorities for medical
treatment"
        codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC">
     <translation code="75320-2" displayName="Advance directive"
codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
  </code>
  <text><reference value="#HealthcareAgents"></reference></text> <!-- LISA: point to
this information. -->
  <statusCode code="completed"/>
  <effectiveTime>
  <!-- The time at which the person named this individual to be his or her
healthcare agent -->
  <low value="20110219"/>
  <!-- Best practice as of July 2017: open time intervals do not use nullflavor.
Simply omit the low or high element to indicate the time interval is open on that
end. -->
  <high nullFlavor="NA"></high> <!-- Populated due to support backwards
compatibility. -->
  </effectiveTime>
  <value xsi:type="CD" code="AD" displayName="Healthcare agent appointment"
         codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT">
  </value>
  <!-- Primary HCA -->
  <participant typeCode="CST">
  <participantRole classCode="AGNT">
  <code code="75783-1" displayName="Primary healthcare agent"
        codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC">
    <originalText>
      <reference value="#HCA-1"></reference>
    </originalText>
  </code>
  <addr nullFlavor="NI"></addr>
  <telecom value="tel:+1(555)555-2008" use="MC"/>
  <telecom value="mailto:zuckerjeff@gmail.com"></telecom>
  <playingEntity>
    <name>
      <given>Jeff</given>
      <family>Zucker</family>
    </name>
   </playingEntity>
  </participantRole>
  </participant>
  <!-- First Alternate HCA -->
  ...
  <!-- Second Alternate HCA -->
  ...
  <!-- Verifier -->
```

```
  ...
  <!-- Point to Source Document Where these Healthcare Agents were verified-->
  ...
</observation>
```

Figure 9: Advance Directive Observation (V5) verifier

```
<!-- ** Advance Directive Observation (V5) ** -->
<observation>
...
<!-- The verifying of this advance directive artifact -->
<participant typeCode="VRF">
<templateId root="2.16.840.1.113883.10.20.1.58"/>
<time value="20170807150000-0500"/>
<participantRole>
  <id extension="5555555555" root="2.16.840.1.113883.4.6"/>
  <code code="207QA0505X" displayName="Adult Medicine"
        codeSystem="2.16.840.1.113883.6.101"
        codeSystemName="Healthcare Provider Taxonomy (HIPAA)"/>
  <playingEntity>
    <name>
      <given>Patricia</given>
      <given qualifier="CL">P.</given>
      <family>Primary</family>
      <suffix qualifier="AC">M.D.</suffix>
    </name>
  </playingEntity>
</participantRole>
</participant>
...
</observation>
```

Figure 10: Advance Directive Observation (V5) Reference External Document

```
<!-- ** Advance Directive Observation (V5) ** -->
<observation>
...
<!-- Information about where the verified artifact is located (can be retrieved) -->
<reference typeCode="REFR">
  <seperatableInd value="false"/>
  <externalDocument>
    <id root="2.16.840.1.113883.4.6.44444" extension="b50b7910-7ffb-4f4c-bbe4-
177ed68cbbf3" />
    <text mediaType="application/pdf">
      <reference value="McBee-Roger-Rienman-2018-01-23-120935.pdf"/>
    </text>
  </externalDocument>
</reference>
...
</observation>
```

Figure 11: Advance Directive Observation (V5) content type with no SNOMED CT code in Value Set

```
<component>
<section>
...
<text>
...
<table>
  <thead>
    <tr>
      <th ID="ADC">Type of Patient Preferences Available:</th>
    </tr>
  </thead>
  <tbody>
    <tr><td ID="ADCT-1">Healthcare agent appointment</td></tr>
    <tr><td ID="ADCT-2">Life support</td></tr>
    <tr><td ID="ADCT-3">Cardiopulmonary resuscitation</td></tr>
    <tr><td ID="ADCT-4">Palliative care</td></tr>
    <tr><td ID="ADCT-5">Organ donation</td></tr>
    <tr><td ID="ADCT-6">Autopsy</td></tr>
    <tr><td ID="ADCT-7">Other directives</td></tr>
  </tbody>
</table>
...
</text>
<entry>
<!-- *** Advance Directive Organizer (V4) template -->
<organizer classCode="CLUSTER" moodCode="EVN">
<templateId root="2.16.840.1.113883.10.20.22.4.108" extension="2022-02-14"/>
...
<component>
  <!-- ** Advance Directive Observation (V5) ** -->
  <observation classCode="OBS" moodCode="EVN">
    <templateId root="2.16.840.1.113883.10.20.22.4.48" extension="2022-02-14"/>
    <id  root="631F0E95-F055-4FA2-AF10-3AE036CAD2EC" extension="10.1.1.6"/>
    <code code="75773-2"
          displayName="Personal goals, preferences, and priorities for medical
treatment"
          codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC">
      <originalText>
        <reference value="#ADC"></reference>
      </originalText>
      <translation code="75320-2"
           displayName="Advance directive"
           codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>
     </code>
    <text><reference value="#ADCT-5"/></text>
     <statusCode code="completed"/>
     <effectiveTime>
       <low value="20110219"/>
       <!-- Best practice as of July 2017: open time intervals do not use
nullflavor.
       Simply omit the low or high element to indicate the time interval is open on
that end. -->
       <high nullFlavor="NA"></high> <!-- Populated due to support backwards
compatibility. -->
     </effectiveTime>
     <value xsi:type="CD" nullFlavor="OTH">
       <originalText>
```

```
          <reference value="#ADCT-5"></reference>
        </originalText>
      </value>
     <participant typeCode="VRF">
     ...
     </participant>
     ...
   </observation>
</component>
```

2.3 Advance Directive Organizer (V4)

[organizer: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2022-02-14 (open)]

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Table 8: Advance Directive Organizer (V4) Contexts

Contained By:	Contains:
Advance Directives Section (entries optional) (V5) (optional) Advance Directives Section (entries required) (V5) (required)	Advance Directive Observation (V5) (required)

This clinical statement groups a set of advance directive observations documented together at a single point in time, and relevant during the episode of care being documented.

The effectiveTime of the organizer (TS) indicates the point in time when the advance directive observations were reviewed/verified. Or, if not reviewed/verified, then the time when the advance directive observations were made. The time element of the author indicates when the advance directive observations were recorded in the patient's record. The effectiveTime of the organizer and the time element of the associated author element may often be the same. Note also for clarity: the effectiveTime of the individual advance directive observations indicates the interval in time when the directive went into effect (effectiveTime/low) and out of effect (effectiveTime/high). The author time element on an advance directive observation indicates the time when the observation was documented.

Table 9: Advance Directive Organizer (V4) Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
organizer (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2022-02-14)					
@classCode	1..1	SHALL		3332-28410	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass) = CLUSTER
@moodCode	1..1	SHALL		3332-28411	urn:oid:2.16.840.1.113883.5.1001 (HL7ActMood) = EVN
templateId	1..1	MAY		3332-28412	
@root	1..1	SHALL		3332-28413	2.16.840.1.113883.10.20.22.4.108
@extension	1..1	SHALL		3332-32876	2015-08-01
templateId	0..1	SHALL		3332-32999	
@root	1..1	SHALL		3332-33000	2.16.840.1.113883.10.20.22.4.108
@extension	1..1	SHALL		3332-33001	2022-02-14
id	1..*	SHALL		3332-28414	
code	1..1	SHALL		3332-28415	
@code	1..1	SHALL		3332-31230	45473-6
@codeSystem	1..1	SHALL		3332-31231	urn:oid:2.16.840.1.113883.6.1 (LOINC)
statusCode	1..1	SHALL		3332-28418	
@code	1..1	SHALL		3332-31346	urn:oid:2.16.840.1.113883.5.14 (HL7ActStatus) = completed
effectiveTime	0..1	SHOULD		3332-33072	
author	0..*	SHOULD		3332-32407	Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119
component	1..*	SHALL		3332-28420	
observation	1..1	SHALL		3332-28421	Advance Directive Observation (V5) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2022-02-14

1. **SHALL** contain exactly one [1..1] **@classCode**="CLUSTER" Cluster (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6) (CONF:3332-28410).
2. **SHALL** contain exactly one [1..1] **@moodCode**="EVN" Event (CodeSystem: HL7ActMood urn:oid:2.16.840.1.113883.5.1001 **STATIC**) (CONF:3332-28411).

3. **MAY** contain exactly one [1..1] **templateId** (CONF:3332-28412) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.108" (CONF:3332-28413).
    b. **SHALL** contain exactly one [1..1] **@extension**="2015-08-01" (CONF:3332-32876).
4. **SHALL** contain zero or one [0..1] **templateId** (CONF:3332-32999) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.108" (CONF:3332-33000).
    b. **SHALL** contain exactly one [1..1] **@extension**="2022-02-14" (CONF:3332-33001).
5. **SHALL** contain at least one [1..*] **id** (CONF:3332-28414).
6. **SHALL** contain exactly one [1..1] **code** (CONF:3332-28415).
    a. This code **SHALL** contain exactly one [1..1] **@code**="45473-6" Advance directive - living will (CONF:3332-31230).
    b. This code **SHALL** contain exactly one [1..1] **@codeSystem** (CodeSystem: LOINC urn:oid:2.16.840.1.113883.6.1 **DYNAMIC**) (CONF:3332-31231).
7. **SHALL** contain exactly one [1..1] **statusCode** (CONF:3332-28418).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**="completed" (CodeSystem: HL7ActStatus urn:oid:2.16.840.1.113883.5.14) (CONF:3332-31346).
8. **SHOULD** contain zero or one [0..1] **effectiveTime** (CONF:3332-33072).
9. **SHOULD** contain zero or more [0..*] Author Participation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.119) (CONF:3332-32407).
10. **SHALL** contain at least one [1..*] **component** (CONF:3332-28420) such that it
    a. **SHALL** contain exactly one [1..1] **Advance Directive Observation (V5)** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2022-02-14) (CONF:3332-28421).

Figure 12: Advance Directive Organizer (V4)

```
<entry>
  <!-- *** Advance Directive Organizer (V4) template -->
  <organizer classCode="CLUSTER" moodCode="EVN">
  <templateId root="2.16.840.1.113883.10.20.22.4.108" extension="2022-02-14"/>
  <id  root="631F0E95-F055-4FA2-AF10-3AE036CAD2EC" extension="10.1.1"/>
  <code code="45473-6" displayName="advance directive - living will"
        codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC">
     <originalText>
       <reference value="#ADorganizer-01"></reference>
     </originalText>
  </code>
  <statusCode code="completed"/>
  <author>
...person documenting the information...
  </author>
  <!-- Documentation of the Person who verified person's advance directives
  and a pointer to the documentation they reviewed. -->
  <component>
  <!-- ** Advance Directive Observation (V5) ** -->
   ...
  <participant typeCode="VRF">
  <templateId root="2.16.840.1.113883.10.20.1.58"/>
  <time value="20170807150000-0500"/>
  <participantRole>
    <id root="20cf14fb-b65c-4c8c-a54d-b0cca834c18c"/>
    <code code="207QA0505X" displayName="Adult Medicine"
codeSystem="2.16.840.1.113883.6.101" codeSystemName="Healthcare Provider Taxonomy
(HIPAA)"/>
    <playingEntity>
     <name> ...</name>
    </playingEntity>
  </participantRole>
  </participant>
  <reference typeCode="REFR">
  <seperatableInd value="false"/>
  <externalDocument>
  <id root="2.16.840.1.113883.4.6.44444"
      extension="b50b7910-7ffb-4f4c-bbe4-177ed68cbbf3" />
  <text mediaType="application/pdf">
    <reference value="McBee-Roger-Rienman-2018-01-23-120935.pdf"/>
  </text>
  </externalDocument>
  </reference>
  </component>
  <!-- Documentation of the type of AD Content verified to be present  -->
  <component>
  <!-- ** Advance Directive Observation (V5) ** -->
  </component>
  <!-- Component content for Healthcare Agent Appointment(s) -->
  <component>
  <!-- ** Advance Directive Observation (V5) ** -->
  </component>
  <component>
  <!-- ** Advance Directive Observation (V5) ** -->
  </component>
 </organizer>
</entry>
```

2.4 Obligation Instruction

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.205:2018-01-01 (open)]

Published as part of Advance Directives - Template Revisions

The Obligation Instruction template is designed to be used within the Advance Directives Section. However, this information also may be relevant within an Interventions Section or a Plan of Treatment Section.

It is an adaptation of the Instruction V2 template. It follows the structure of an instruction template, but modifies the semantics in two ways. First, the code element comes from a value set containing concepts that are types of Obligation Instructions that a patient, or a patient's healthcare agent or other type of surrogate decision-maker may decide to make when the patient is unable to communicate. Second, the author of this template is the person who made the decision documented in the Obligation Instruction.

The Obligation Instruction template and Prohibition Instruction template are designed as a "matched pair" to permit either prohibitions or obligations to be clearly expressed in an unambiguous way. The use of negation is explicitly expressed, and the semantic design of the recommended value sets takes into consideration the logical meaning of an obligation versus a prohibition. The Obligation Instruction template explicitly prohibits the use of negationInd. It always expresses activities that care providers have been instructed to perform. Coded concepts used in this template express activities in the positive.

For decisions that establish prohibition instructions, refer to the Prohibition Instruction template.

Table 10: Obligation Instruction Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.205:2018-01-01)					
@classCode	1..1	SHALL		3332-33030	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		3332-33031	urn:oid:2.16.840.1.113883.5.1001 (HL7ActMood) = INT
@negationInd	0..0	SHALL NOT		3332-33040	
templateId	1..1	SHALL		3332-33021	
@root	1..1	SHALL		3332-33027	2.16.840.1.113883.10.20.22.4.205
@extension	1..1	SHALL		3332-33028	2018-01-01
code	1..1	SHALL		3332-33023	urn:oid:2.16.840.1.113883.11.20.9.69.17 (Obligation or Prohibition Instruction Type)
@nullFlavor	0..1	MAY		3332-33033	
originalText	0..1	MAY		3332-33032	
translation	0..*	MAY		3332-33034	
text	1..1	SHALL		3332-33041	
statusCode	1..1	SHALL		3332-33022	
@code	1..1	SHALL		3332-33029	urn:oid:2.16.840.1.113762.1.4.1115.2 (InstructionActStatus)
effectiveTime	1..1	SHALL		3332-33024	
@nullFlavor	0..0	SHALL NOT		3332-33037	
low	1..1	SHALL		3332-33025	
@nullFlavor	0..0	SHALL NOT		3332-33035	
high	0..1	MAY		3332-33036	
author	1..1	SHALL		3332-33026	
@nullFlavor	0..0	SHALL NOT		3332-33038	
time	1..1	SHALL		3332-33039	

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 **STATIC**) (CONF:3332-33030).
2. **SHALL** contain exactly one [1..1] **@moodCode**="INT" Intent (CodeSystem: HL7ActMood urn:oid:2.16.840.1.113883.5.1001 **STATIC**) (CONF:3332-33031).
3. **SHALL NOT** contain [0..0] **@negationInd** (CONF:3332-33040).
4. **SHALL** contain exactly one [1..1] **templateId** (CONF:3332-33021) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.205" (CONF:3332-33027).
    b. **SHALL** contain exactly one [1..1] **@extension**="2018-01-01" (CONF:3332-33028).
5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **Obligation or Prohibition Instruction Type** urn:oid:2.16.840.1.113883.11.20.9.69.17 **DYNAMIC** (CONF:3332-33023).

Use nullFlavor="OTH" for activities that do not have a code in the existing value set.

    a. This code **MAY** contain zero or one [0..1] **@nullFlavor** (CONF:3332-33033).

OriginalText may be used any time to anchor the coded concept to the original information.

    b. This code **MAY** contain zero or one [0..1] **originalText** (CONF:3332-33032).

Use translation if a coded concept is available for the activity or if a more specific coded concept is available for the activity.

    c. This code **MAY** contain zero or more [0..*] **translation** (CONF:3332-33034).
6. **SHALL** contain exactly one [1..1] **text** (CONF:3332-33041).
7. **SHALL** contain exactly one [1..1] **statusCode** (CONF:3332-33022).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **InstructionActStatus** urn:oid:2.16.840.1.113762.1.4.1115.2 **DYNAMIC** (CONF:3332-33029).
8. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:3332-33024).
    a. This effectiveTime **SHALL NOT** contain [0..0] **@nullFlavor** (CONF:3332-33037).

The effectiveTime/low indicates the time when the obligation becomes effective.

    b. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:3332-33025).
        i. This low **SHALL NOT** contain [0..0] **@nullFlavor** (CONF:3332-33035).

When present, the effectiveTime/high indicates the time when the obligation instruction is no longer in effect.

    c. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:3332-33036).

The author indicates the person who made the decision to put this obligation instruction into effect. It can be the patient, the appointed healthcare agent or other type of surrogate decision-maker if the patient cannot communicate, or a healthcare provider acting in the patient's interest when no healthcare agent or other type of surrogate decision-maker has been appointed and the patient cannot communicate.

9. **SHALL** contain exactly one [1..1] **author** (CONF:3332-33026).
    a. This author **SHALL NOT** contain [0..0] **@nullFlavor** (CONF:3332-33038).

The author/time indicates when the obligation instruction was established. (This could be in advance of when it takes effect.) It is the time the author made the decision to issue the obligation instruction.

b. This author **SHALL** contain exactly one [1..1] **time** (CONF:3332-33039).

Figure 13: Obligation Instruction

```
<!-- In the narrative of the Advance Directives Section, or Interventions Section,
or Plan of Treatment Section -->
<content styleCode="Bold">Obligation Instructions</content><br/>
<content>Associated Encounter: Inpatient Stay (8/7/2017- 8/10/2017) </content><br/>
<content>(Documented by: Nancy Nightingale, RN August 07, 2017 4:30
pm)</content><br/>
<table ID="ADOI">
 <thead>
  <tr>
    <th>Type of Care Requested:</th>
    <th>As of:</th>
    <th>Signed by:</th>
    <th>Patient Care Decision Form</th>
  </tr>
 </thead>
 <tbody>
  <tr ID="ADOI-01">
    <td ID="ADOI-01-Care">Palliative Care</td>
    <td>8/7/2017 11:30am</td>
    <td>Jeff Zucker</td>
    <td>
      <linkHtml href="Form_for_Patient_Care_Decision-making.pdf">Signed Care
Decision-Making Form for this encounter</linkHtml>
    </td>
  </tr>
 </tbody>
</table>
<!-- The associated Machine Readable entry information -->
<!-- Obligation Instruction for Palliative Care -->
<entry>
  <act classCode="ACT" moodCode="INT">
  <templateId root="2.16.840.1.113883.10.20.22.4.205" extension="2018-01-01"/>
  <code code="103735009" displayName="Palliative care (regime/therapy)"
        codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT">
    <originalText><reference value="ADOI-01-Care"></reference> </originalText>
  </code>
  <text><reference value="#ADOI-01"></reference></text>
  <statusCode code="Active"/>
  <effectiveTime>
    <low value="201708071130-0500"/>
  </effectiveTime>
  <author>
    <time value="201708071630-0500"/>
    <assignedAuthor>
    <id/>
      <assignedPerson>
        <name>Nancy Nightingale, RN</name>
      </assignedPerson>
    </assignedAuthor>
  </author>
  <participant typeCode="AUTHEN">
    <time value="201708071130-0500"/>
    <participantRole>
      <id/>
      <playingEntity>
         <name>Jeff Zucker</name>
      </playingEntity>
```

```
    </participantRole>
  </participant>
  <!--Use established patterns for link to
      the specific encounter where this obligation applies -->
  <entryRelationship typeCode="COMP" inversionInd="true">
    <encounter classCode="ENC" moodCode="EVN">
    <id root="2a620155-9d11-439e-92b3-5d9815ff4de8" extension="2"/> <!-- The
referenced Encounter -->
      <code nullFlavor="NP"></code>
    </encounter>
  </entryRelationship>
</act>
</entry>
```

2.5 Prohibition Instruction

[act: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.206:2018-01-01 (open)]

Published as part of Advance Directives - Template Revisions

The Prohibition Instruction template is designed to be used within the Advance Directives Section. However, this information also may be relevant within an Interventions Section or a Plan of Treatment Section.

It is an adaptation of the Instruction V2 template. It follows the structure of an instruction template, but modifies the semantics in several ways. First, the code element comes from a value set containing concepts that are types of care instructions about activities that a patient, or a patient's healthcare agent or other type of surrogate decision-maker (when the patient is unable to communicate) does not want care providers to perform. Second, the author of this template is the person who made the decision documented in the Prohibition Instruction.

The Prohibition Instruction template and Obligation Instruction template are designed as a "matched pair" to permit either prohibitions or obligations to be clearly expressed in an unambiguous way. The use of negation is explicitly expressed, and the semantic design of the recommended value sets takes into consideration the logical meaning of an obligation versus a prohibition. The Prohibition Instruction template explicitly requires the use of negationInd=”true”. It always expresses activities that care providers have been instructed not to perform. Coded concepts used in this template express activities in the positive and add semantics for negation through the structural negationInd attribute.

For decisions that establish obligation instructions, refer to the ObligationInstruction template.

Table 11: Prohibition Instruction Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
act (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.206:2018-01-01)					
@classCode	1..1	SHALL		3332-33051	urn:oid:2.16.840.1.113883.5.6 (HL7ActClass) = ACT
@moodCode	1..1	SHALL		3332-33052	urn:oid:2.16.840.1.113883.5.1001 (HL7ActMood) = INT
@negationInd	1..1	SHALL		3332-33056	true
templateId	1..1	SHALL		3332-33042	
@root	1..1	SHALL		3332-33048	2.16.840.1.113883.10.20.22.4.206
@extension	1..1	SHALL		3332-33049	2018-01-01
code	1..1	SHALL		3332-33044	urn:oid:2.16.840.1.113883.11.20.9.69.17 (Obligation or Prohibition Instruction Type)
@nullFlavor	0..1	MAY		3332-33053	
originalText	0..1	MAY		3332-33054	
translation	0..*	MAY		3332-33055	
statusCode	1..1	SHALL		3332-33043	
@code	1..1	SHALL		3332-33050	urn:oid:2.16.840.1.113762.1.4.1115.2 (InstructionActStatus)
effectiveTime	1..1	SHALL		3332-33045	
low	1..1	SHALL		3332-33046	
@nullFlavor	0..0	SHALL NOT		3332-33057	
high	0..1	MAY		3332-33058	
author	1..1	SHALL		3332-33047	
@nullFlavor	0..0	SHALL NOT		3332-33059	
time	1..1	SHALL		3332-33060	

1. **SHALL** contain exactly one [1..1] **@classCode**="ACT" (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6 **STATIC**) (CONF:3332-33051).

2. **SHALL** contain exactly one [1..1] **@moodCode**="INT" Intent (CodeSystem: HL7ActMood urn:oid:2.16.840.1.113883.5.1001 **STATIC**) (CONF:3332-33052).
3. **SHALL** contain exactly one [1..1] **@negationInd**="true" (CONF:3332-33056).
4. **SHALL** contain exactly one [1..1] **templateId** (CONF:3332-33042) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.4.206" (CONF:3332-33048).
    b. **SHALL** contain exactly one [1..1] **@extension**="2018-01-01" (CONF:3332-33049).
5. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **Obligation or Prohibition Instruction Type** urn:oid:2.16.840.1.113883.11.20.9.69.17 **DYNAMIC** (CONF:3332-33044).

Use nullFlavor="OTH" for activities that do not have a code in the existing value set.

    a. This code **MAY** contain zero or one [0..1] **@nullFlavor** (CONF:3332-33053).

OriginalText may be used any time to anchor the coded concept to the orginal information.

    b. This code **MAY** contain zero or one [0..1] **originalText** (CONF:3332-33054).

Use translation if a coded concept is available for the activity or if a more specific coded concept is available for the activity.

    c. This code **MAY** contain zero or more [0..*] **translation** (CONF:3332-33055).
6. **SHALL** contain exactly one [1..1] **statusCode** (CONF:3332-33043).
    a. This statusCode **SHALL** contain exactly one [1..1] **@code**, which **SHALL** be selected from ValueSet **InstructionActStatus** urn:oid:2.16.840.1.113762.1.4.1115.2 **DYNAMIC** (CONF:3332-33050).
7. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:3332-33045).

The effectiveTime/low indicates the time when the obligation becomes effective.

    a. This effectiveTime **SHALL** contain exactly one [1..1] **low** (CONF:3332-33046).
        i. This low **SHALL NOT** contain [0..0] **@nullFlavor** (CONF:3332-33057).

When present, the effectiveTime/high indicates the time when the prohibition instruction is no longer in effect.

    b. This effectiveTime **MAY** contain zero or one [0..1] **high** (CONF:3332-33058).

The author indicates the person who made the decision to put this obligation instruction into effect. It can be the patient, the appointed healthcare agent or other type of surrogate decision-maker if the patient cannot communicate, or a healthcare provider acting in the patient's interest when no healthcare agent or other type of surrogate decision-maker has been appointed and the patient cannot communicate.

8. **SHALL** contain exactly one [1..1] **author** (CONF:3332-33047).
    a. This author **SHALL NOT** contain [0..0] **@nullFlavor** (CONF:3332-33059).

The author/time indicates when the prohibition instruction was established. (This could be in advance of when it takes effect.) It is the time the author made the decision to issue the prohibition instruction.

    b. This author **SHALL** contain exactly one [1..1] **time** (CONF:3332-33060).

Figure 14: Prohibition Instruction

```
<!-- Narrative text for a Prohibition Instruction -->
<content styleCode="Bold">Prohibition Instructions</content><br/>
<content>Associated Encounter: Inpatient Stay (8/7/2017- 8/10/2017) </content><br/>
<content>(Documented by: Nancy Nightingale, RN August 07, 2017 4:30
pm)</content><br/>
<table ID="ADPI">
  <thead>
    <tr>
      <th>Type of Care Prohibited:</th>
      <th>As of:</th>
      <th>Signed by:</th>
      <th>Patient Care Decision Form</th>
    </tr>
  </thead>
  <tbody>
    <tr ID="ADPI-01">
      <td ID="ADPI-01-Care">Cardiopulmonary resuscitation</td>
      <td>8/7/2017 11:30am</td>
      <td>Jeff Zucker</td>
      <td>
        <linkHtml href="Form_for_Patient_Care_Decision-making.pdf">Signed Care
Decision-Making Form for this encounter</linkHtml>
      </td>
    </tr>
  </tbody>
</table>
<!-- Corresponding Machine Readable Entry -->
<!-- Prohibition Instruction for CPR-->
<entry>
  <act classCode="ACT" moodCode="INT" negationInd="true">
    <templateId root="2.16.840.1.113883.10.20.22.4.206" extension="2018-01-01"/>
    <code code="8966600" displayName="Cardiopulmonary resuscitation (procedure)"
          codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT">
      <originalText></originalText>
    </code>
    <text><reference value="#ADPI-01"></reference></text>
    <statusCode code="Active"/>
    <effectiveTime>
      <low value="201708071130"/>
    </effectiveTime>
    <author>
      <time value="201708071630-0500"/>
      <assignedAuthor>
        <id/>
        <assignedPerson>
          <name>Nancy Nightingale, RN</name>
        </assignedPerson>
      </assignedAuthor>
    </author>
    <participant typeCode="AUTHEN">
      <time value="201708071130-0500"/>
      <participantRole>
        <id/>
        <playingEntity>
          <name>Jeff Zucker</name>
        </playingEntity>
      </participantRole>
```

```
    </participant>
    <entryRelationship typeCode="COMP" inversionInd="true">
      <encounter classCode="ENC" moodCode="EVN">
        <id root="2a620155-9d11-439e-92b3-5d9815ff4de8" extension="2"/> <!-- The
referenced Encounter -->
        <code nullFlavor="NP"></code>
      </encounter>
    </entryRelationship>
  </act>
</entry>
```

3 Template Ids in This Guide

Table 12: Template List

Template Title	Template Type	templateId
Advance Directives Section (entries optional) (V5)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2022-02-14
Advance Directives Section (entries required) (V5)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.21.1:2022-02-14
Advance Care Planning Intervention (V1)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.204:2017-05-01
Advance Directive Observation (V5)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2022-02-14
Advance Directive Organizer (V4)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2022-02-14
Obligation Instruction	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.205:2018-01-01
Prohibition Instruction	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.206:2018-01-01

Table 13: Template Containments

Template Title	Template Type	templateId
Advance Care Planning Intervention (V1)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.204:2017-05-01
Obligation Instruction	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.205:2018-01-01
Prohibition Instruction	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.206:2018-01-01
Advance Directives Section (entries optional) (V5)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.21:2022-02-14
Advance Directive Organizer (V4)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2022-02-14
Advance Directive Observation (V5)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2022-02-14
Advance Directives Section (entries required) (V5)	section	urn:hl7ii:2.16.840.1.113883.10.20.22.2.21.1:2022-02-14
Advance Directive Observation (V5)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2022-02-14
Advance Directive Organizer (V4)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.108:2022-02-14
Advance Directive Observation (V5)	entry	urn:hl7ii:2.16.840.1.113883.10.20.22.4.48:2022-02-14

4 Value Sets In This Guide

Table 14: Advance Care Planning Services Grouping

Value Set: Advance Care Planning Services Grouping urn:oid:2.16.840.1.113883.11.20.9.69.1.3

(Clinical Focus: Concepts that express advance care planning services.),(Data Element Scope: Advance care planning service.),(Inclusion Criteria: Codes from member value sets used to indicate advance care planning services expressed as CPT or SNOMED CT.),(Exclusion Criteria:)

This value set was imported on 2/28/2022 with a version of Latest.

Value Set Source:
https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.69.1.3/expansion

Code	Code System	Code System OID	Print Name
713603004	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Advance care planning (procedure)
713604005	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Education about advance care planning (procedure)
713662007	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Discussion about advance care planning (procedure)
99497	CPT4	urn:oid:2.16.840.1.113883.6.12	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	CPT4	urn:oid:2.16.840.1.113883.6.12	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

Table 15: ProcedureAct statusCode

Value Set: ProcedureAct statusCode urn:oid:2.16.840.1.113883.11.20.9.22 (Clinical Focus: Status of a procedure activity),(Data Element Scope:),(Inclusion Criteria:),(Exclusion Criteria:) This value set was imported on 4/24/2019 with a version of 20190103. Value Set Source: https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.22/expansion			
Code	**Code System**	**Code System OID**	**Print Name**
aborted	HL7ActStatus	urn:oid:2.16.840.1.113883.5.14	aborted
active	HL7ActStatus	urn:oid:2.16.840.1.113883.5.14	active
cancelled	HL7ActStatus	urn:oid:2.16.840.1.113883.5.14	cancelled
completed	HL7ActStatus	urn:oid:2.16.840.1.113883.5.14	completed

Table 16: Planned or Completed moodCode

Value Set: Planned or Completed moodCode urn:oid:2.16.840.1.113883.11.20.9.69.6 (Clinical Focus: This value set includes the actMood codes required to express planned or completed acts.),(Data Element Scope: moodCodes for planned or completed acts.),(Inclusion Criteria: Include concepts from the actMood code system that are relevant moods for acts that need to be documented as planned (for the future) or as having been completed.),(Exclusion Criteria: exclude concepts from the actMood code system that are not relevant for planned or completed acts.) This value set was imported on 11/22/2021 with a version of Latest. Value Set Source: https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.69.6/expansion			
Code	**Code System**	**Code System OID**	**Print Name**
APT	HL7ActMood	urn:oid:2.16.840.1.113883.5.1001	appointment
ARQ	HL7ActMood	urn:oid:2.16.840.1.113883.5.1001	appointment request
EVN	HL7ActMood	urn:oid:2.16.840.1.113883.5.1001	event (occurrence)
INT	HL7ActMood	urn:oid:2.16.840.1.113883.5.1001	intent
PRMS	HL7ActMood	urn:oid:2.16.840.1.113883.5.1001	promise
PRP	HL7ActMood	urn:oid:2.16.840.1.113883.5.1001	proposal
RQO	HL7ActMood	urn:oid:2.16.840.1.113883.5.1001	request

Table 17: Advance Directives Categories

Value Set: Advance Directives Categories urn:oid:2.16.840.1.113883.11.20.9.69.4

(Clinical Focus: Categories of Advance Directives.),(Data Element Scope: Concepts represent different categories of Advance Directive statements.),(Inclusion Criteria: Includes concepts from LOINC that indicate a category (or kind) of advance directive that may be specified in a standard advance directive document.),(Exclusion Criteria:)

This value set was imported on 2/28/2022 with a version of Latest.

Value Set Source:
https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.69.4/expansion

Code	Code System	Code System OID	Print Name
64298-3	LOINC	urn:oid:2.16.840.1.113883.6.1	Power of attorney
81334-5	LOINC	urn:oid:2.16.840.1.113883.6.1	Patient Personal advance care plan
86533-7	LOINC	urn:oid:2.16.840.1.113883.6.1	Patient Living will
92664-2	LOINC	urn:oid:2.16.840.1.113883.6.1	Power of attorney and Living will

Table 18: Advance Directive Content Type SCT

Value Set: Advance Directive Content Type SCT urn:oid:2.16.840.1.113762.1.4.1115.5

(Clinical Focus: Types of content that may be found in a person's advance directives.),(Data Element Scope: Types of content that may be found in a person's advance directives),(Inclusion Criteria: Concepts from SCT used to identify the type of content that may be expressed in a person's advance directives.),(Exclusion Criteria:)

This value set was imported on 6/29/2019 with a version of 20190319.

Value Set Source:
https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1115.5/expansion

Code	Code System	Code System OID	Print Name
103735009	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Palliative care (regime/therapy)
108259003	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Autopsy pathology procedure AND/OR service (procedure)
225365006	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Care regime (regime/therapy)
229912004	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Enteral feeding (regime/therapy)
281789004	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Antibiotic therapy (procedure)
281800008	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Intravenous fluid replacement (procedure)
363259005	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Patient management procedure (procedure)
385741000	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Management of funeral arrangements (procedure)
385763009	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Hospice care (regime/therapy)
386367000	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Mutual goal setting (regime/therapy)
...			

Table 19: Healthcare Provider Taxonomy

Value Set: Healthcare Provider Taxonomy urn:oid:2.16.840.1.114222.4.11.1066

(Clinical Focus: Represent the "type" of health care provider individual or organization using the National Uniform Claims Committee (NUCC) code system),(Data Element Scope: The assignedEntity attribute),(Inclusion Criteria: All codes in the NUCC Provider Taxonomy code system),(Exclusion Criteria: None)

This value set was imported on 6/24/2019 with a version of 20190521.

Value Set Source:
https://vsac.nlm.nih.gov/valueset/2.16.840.1.114222.4.11.1066/expansion

Code	Code System	Code System OID	Print Name
10	Healthcare Provider Taxonomy (HIPAA)	urn:oid:2.16.840.1.113883.6.101	Provider has a medical condition that impairs or limits him/her to practice
101Y00000X	Healthcare Provider Taxonomy (HIPAA)	urn:oid:2.16.840.1.113883.6.101	Behavioral Health & Social Service Providers; Counselor
101YA0400X	Healthcare Provider Taxonomy (HIPAA)	urn:oid:2.16.840.1.113883.6.101	Behavioral Health & Social Service Providers; Counselor, Addiction (Substance Use Disorder)
101YM0800X	Healthcare Provider Taxonomy (HIPAA)	urn:oid:2.16.840.1.113883.6.101	Behavioral Health & Social Service Providers; Counselor, Mental Health
101YP1600X	Healthcare Provider Taxonomy (HIPAA)	urn:oid:2.16.840.1.113883.6.101	Behavioral Health & Social Service Providers; Counselor, Pastoral
101YP2500X	Healthcare Provider Taxonomy (HIPAA)	urn:oid:2.16.840.1.113883.6.101	Behavioral Health & Social Service Providers; Counselor, Professional
101YS0200X	Healthcare Provider Taxonomy (HIPAA)	urn:oid:2.16.840.1.113883.6.101	Behavioral Health & Social Service Providers; Counselor, School
102L00000X	Healthcare Provider Taxonomy (HIPAA)	urn:oid:2.16.840.1.113883.6.101	Behavioral Health & Social Service Providers; Psychoanalyst
102X00000X	Healthcare Provider Taxonomy (HIPAA)	urn:oid:2.16.840.1.113883.6.101	Behavioral Health & Social Service Providers; Poetry Therapist
103G00000X	Healthcare Provider Taxonomy (HIPAA)	urn:oid:2.16.840.1.113883.6.101	Behavioral Health & Social Service Providers; Clinical Neuropsychologist
...			

Table 20: Healthcare Agent or Proxy Choices

Value Set: Healthcare Agent or Proxy Choices urn:oid:2.16.840.1.113762.1.4.1046.35 (Clinical Focus: This value set identifies the healthcare agent or proxy roles that individuals commonly designate to empower surrogates to make medical treatment and care decisions when the individual is unable to effectively communicate with medical personnel or requires assistance with decision making.),(Data Element Scope: The intent of this value set is to identify the questions used to determine an individual's choices for a healthcare agent or proxy, including the designation of surrogates.),(Inclusion Criteria: The value set is defined by this list of concepts.),(Exclusion Criteria: n/a) This value set was imported on 7/16/2019 with a version of 20190114. Value Set Source: **https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1046.35/expansion**			
Code	**Code System**	**Code System OID**	**Print Name**
75783-1	LOINC	urn:oid:2.16.840.1.113883.6.1	Primary healthcare agent [Reported]
75784-9	LOINC	urn:oid:2.16.840.1.113883.6.1	First alternate healthcare agent [Reported]
75785-6	LOINC	urn:oid:2.16.840.1.113883.6.1	Second alternate healthcare agent [Reported]
81335-2	LOINC	urn:oid:2.16.840.1.113883.6.1	Patient Healthcare agent

Table 21: Obligation or Prohibition Instruction Type

Value Set: Obligation or Prohibition Instruction Type urn:oid:2.16.840.1.113883.11.20.9.69.17

(Clinical Focus: Types of obligation/prohibition instructions that may be provided by a patient or by a patient's healthcare agent when the patient can't communicate.),(Data Element Scope: SNOMED CT concepts expressing types of obligation/prohibition instructions that may be provided by a patient or by a patient's healthcare agent when the patient can't communicate.),(Inclusion Criteria: Selected SNOMED CT concepts expressing types of obligation/prohibition instructions that may be provided by a patient or by a patient's healthcare agent when the patient can't communicate.),(Exclusion Criteria:)

This value set was imported on 11/19/2021 with a version of Latest.

Value Set Source:
https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.69.17/expansion

Code	Code System	Code System OID	Print Name
103735009	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Palliative care (regime/therapy)
229912004	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Enteral feeding (regime/therapy)
232969009	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Cardiac support using extracorporeal membrane oxygenation circuitry (procedure)
281789004	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Antibiotic therapy (procedure)
281800008	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Intravenous fluid replacement (procedure)
385763009	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Hospice care (regime/therapy)
52765003	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Intubation (procedure)
61420007	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Tube feeding of patient (regime/therapy)
78823007	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Life support procedure (procedure)
89666000	SNOMED CT	urn:oid:2.16.840.1.113883.6.96	Cardiopulmonary resuscitation (procedure)

Table 22: InstructionActStatus

Value Set: InstructionActStatus urn:oid:2.16.840.1.113762.1.4.1115.2

(Clinical Focus: This value set holds the state model concepts for an Obligation Instruction or Prohibition Instruction. These are instructions that a patient, or a patient's healthcare agent or other type of surrogate decision-maker may decide to make when the patient is unable to communicate),(Data Element Scope:),(Inclusion Criteria: Includes completed and active),(Exclusion Criteria:)

This value set was imported on 2/28/2022 with a version of Latest.

Value Set Source:
https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1115.2/expansion

Code	Code System	Code System OID	Print Name
active	HL7ActStatus	urn:oid:2.16.840.1.113883.5.14	active
completed	HL7ActStatus	urn:oid:2.16.840.1.113883.5.14	completed

5 Code Systems in This Guide

Table 23: Code Systems

Name	OID
CPT4	urn:oid:2.16.840.1.113883.6.12
Healthcare Provider Taxonomy (HIPAA)	urn:oid:2.16.840.1.113883.6.101
HL7ActClass	urn:oid:2.16.840.1.113883.5.6
HL7ActMood	urn:oid:2.16.840.1.113883.5.1001
HL7ActRelationshipType	urn:oid:2.16.840.1.113883.5.1002
HL7ActStatus	urn:oid:2.16.840.1.113883.5.14
HL7NullFlavor	urn:oid:2.16.840.1.113883.5.1008
HL7ParticipationType	urn:oid:2.16.840.1.113883.5.90
HL7RoleClass	urn:oid:2.16.840.1.113883.5.110
LOINC	urn:oid:2.16.840.1.113883.6.1
SNOMED CT	urn:oid:2.16.840.1.113883.6.96