Implementation Guide for CDA Release 2
ToC Consolidated CDA IG
Working Group Draft

PROTOTYPE: FOR DISCUSSION AND DEMONSTRATION USE ONLY

Contents

Acknowledgement **5**
Revision History **7**

Chapter 1: INTRODUCTION **9**
Overview 10
Approach 10
Scope 10
Organization of This Guide 11
Conventions Used in This Guide 11
Conformance Requirements 11
Keywords 12
XML Examples 12

Chapter 2: DOCUMENT TEMPLATES **13**
Consultation Request 14
Consultation Summary 15
Discharge Instructions 16
Discharge Summary 17

Chapter 3: SECTION TEMPLATES **19**

Chapter 4: VALUE SETS **21**
Administrative Gender Code 23
Administrative Gender (HL7 V3) 23
Admission Type (NUBC) 23
Advance Directive Type 23
Age P Q_ UCUM 24
Allergy/Adverse Event Type 24
Basic Confidentiality Kind 25
Body Site 25
Confidentiality Code 25
Consult Document Type 25
Coverage Type Value Set 26
DCM 26
DICOMPurposeOfReference 26
DIR Document Type Codes 26
Discharge Summary Document Type Code 26
Encounter Type 26
HITSP Problem Status 27
HL7 Financially Responsible Party Type 27
HP Document Type 27
Health Insurance Type 27
Healthcare Provider Taxonomy 30
Healthcare Service Location 30
Ingredient Name 30
Language 30
Language Ability Mode 30

Language Ability Proficiency..... 31
Marital Status..... 31
Medication Brand Name..... 31
Medication Clinical Drug..... 32
Medication Drug Class..... 32
Medication Fill Status..... 32
Medication Product Form..... 32
Medication Route FDA..... 33
Medication Type..... 33
Mood Code Evn Int..... 33
NUCC Health Care Provider Taxonomy..... 33
No Immunization Reason..... 34
Observation Interpretation (HL7)..... 34
Participationsignature..... 34
Patient Education..... 34
Personal Relationship Role Type..... 34
Problem..... 36
Problem Act Status Code..... 36
Problem Severity..... 36
Problem Type..... 37
Procedure Act Status Code..... 37
Procedure Note Document Type Codes..... 38
Progress Note Document Type Code..... 38
Provider Type..... 38
Race..... 38
Religious Affiliation..... 38
Role Code..... 38
Severity Observation..... 39
Social History Type..... 39
Surgical Operation Note Document Type Code..... 39
Vaccines administered (CVX)..... 39
Vital Sign Result..... 40
REFERENCES..... 41

Acknowledgement

This guide was produced through the Office of the National Coordinator (ONC) within the US Department of Health and Human Services (HSS).

The Initiative was carried out within the ONC's Standards and Interoperability S&I Framework as the Transition of Care (ToC) Initiative with the goal being to improve the exchange of core clinical information among providers, patients and other authorized entities electronically in support of meaningful use and IOM-identified needs for improvement in the quality of care. for the US Realm. The scope of this Initiative is as its first priority support for Meaningful Use Stage 1 summary of care (Eligible Provider, Eligible Hospital, and Critical Access Hospital) requirements for transition of care and transition of care to consumer and as a second priority support for expected Stage 2 requirements.

The conformance requirements included here for review were generated from the Model-Driven Health Tools (MDHT)-developed as an open source tool under the auspices of the Veterans Administration, IBM, and the ONC; using the output from the the Clinical Document Architecture (CDA) Consolidation Project, another project carried out within the ONC's Standards and Interoperability S&I Framework, and released through Health Level Seven (HL7).

This document contains an example of healthcare standards and specifications publication generated from UML models using the OHT Model Drivent Health Tools (MDHT). Some portions of this document may not be publicly available, but are included for demonstration purposes only, therefore this version of the document is to be treated as CONFIDENTIAL by the project participants.

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Revision History

Rev	Date	By Whom	Changes
New	Jan 2012	Rama Ramakrishnan	Initial creation
v 1.0	February 2012	Rama Ramakrishnan	Updated model content

Chapter 1

INTRODUCTION

Topics:

- *Overview*
- *Approach*
- *Scope*
- *Organization of This Guide*
- *Conventions Used in This Guide*

Overview

This implementation guide is generated from UML models developed in the Open Health Tools (OHT) Model-Driven Health Tools (MDHT) project. The data specifications have been formalized into computational models expressed in UML. These models are used by automated tooling to generate this publication, plus validation tools and Java libraries for implementers.

Approach

Working with an initial portion of the data provides the opportunity to work with the data from the perspective of the underlying model and electronic format and to explore many design issues thoroughly. Taking this as an initial step ensures that the data set developers and standards community can reach consensus prior to the larger commitment of time that would be required to bring the full data set into standard format.

This project supports reusability and ease of data collection through a standard data representation harmonized with work developed through Health Information Technology Expert Panel (HITEP), balloted through Health Level Seven (HL7) and/or recognized by the Health Information Technology Standards Panel (HITSP).

This implementation guide (IG) specifies a standard for electronic submission of NCRs in a Clinical Document Architecture (CDA), Release 2 format.

In the development of this specification, the Transition of Care team reviewed the requirements set forth in the ToC Use Case, identified and reviewed artifacts relevant to those requirements and performed an analysis to determine the data elements, metadata and vocabularies needed to support those requirements. As a result of that analysis, it was determined that the HL7 Implementation Guide for CDA Release 2.0 Consolidated CDA Templates (US Realm) most closely reflected the ToC requirements.

The ToC team members then layered the additional ToC constraints upon the HL7 Implementation Guide for CDA Release 2.0 Consolidated CDA Templates (US Realm).

The major document template additions for ToC which have been created by the ONC S&I Framework are defined by document. All of the remaining section and entry templates are to be used from the existing HL7 Implementation Guide for CDA Release 2.0 Consolidated CDA Templates (US Realm) and may be found in that document.

All of the Conformance requirements and value set tables used by the ToC CDA Documents are those specified by the Consolidated CDA Templates as published by the Implementation Guide for CDA Release 2.0 Consolidated CDA Templates (US Realm), with the exception of the document level CDA templates published within this document.

Both the Implemenation Guide for ToC CDA Consolidation and the Implementation Guide for CDA Release 2.0 Consolidated CDA Templates (US Realm) are currently released for Trial Implementation.

Scope

This document is scoped by the content of the ONC's Standards and Interoperability (S&I) Framework Transition of Care (ToC) Initiative and the Implementation Guide for CDA Release 2.0 Consolidated CDA Templates (US Realm).

The four CDA Document templates required for ToC are included in this guide. The conformance rules for these document templates are in accordance to the specifications required by the ToC Initiative. The definitions and the conformance requirements for the section level and entry level templates are to be drawn directly from the Implementation Guide for CDA Release 2.0 Consolidated CDA Templates (US Realm).

This guide fully specifies a compliant CDA R2 document for each document type.

Additional optional CDA elements, not included here, can be included and the result will be compliant with the documents in this standard.

Organization of This Guide

This guide includes a set of CDA Templates, and prescribes their use for a set of specific document types. The main chapters are:

Chapter 1. Introduction. This chapter provides a brief introduction and the scope about this document.

Chapter 2. Document-level Templates. This chapter defines each of the four document types. It defines header constraints specific to each and the section-level templates (required) for each.

Chapter 3. Section-level Templates. This chapter defines the section templates referenced within the document types described here. Sections are atomic units, and can be reused by future specifications. ***All section level templates defined for the document types are referenced from the HL7 CDA Consolidation Guide DSTU (Dec 2011).***

Chapter 4. Value Sets. This chapter defines the value sets referenced within the ToC CDA document templates.

Conventions Used in This Guide

Conformance Requirements

Conformance statements are grouped and identified by the name of the template, along with the templateId and the context of the template (e.g., ClinicalDocument, section, observation), which specifies the element under constraint. If a template is a specialization of another template, its first constraint indicates the more general template. In all cases where a more specific template conforms to a more general template, asserting the more specific template also implies conformance to the more general template. An example is shown below.

Template name

```
[<type of template>: templateId <XXXX.XX.XXX.XXX>]
```

Description of the template will be here .....

1. Conforms to <The template name> Template (templateId: XXXX<XX>XXX>YYY).
2. **SHALL** contain [1..1] @classCode = <AAA> <code display name> (CodeSystem: 123.456.789 <XXX> Class) **STATIC** (CONF:<number>).
3. .....

Figure 1: Template name and "conforms to" appearance

The conformance verb keyword at the start of a constraint (**SHALL** , **SHOULD** , **MAY**, etc.) indicates business conformance, whereas the cardinality indicator (0..1, 1..1, 1..*, etc.) specifies the allowable occurrences within an instance. Thus, " **MAY** contain 0..1" and " **SHOULD** contain 0..1" both allow for a document to omit the particular component, but the latter is a stronger recommendation that the component be included if it is known.

The following cardinality indicators may be interpreted as follows:

0..1 as zero to one present
1..1 as one and only one present
2..2 as two must be present
1..* as one or more present
0..* as zero to many present

Value set bindings adhere to HL7 Vocabulary Working Group best practices, and include both a conformance verb (**SHALL** , **SHOULD** , **MAY,** etc.) and an indication of **DYNAMIC** vs. **STATIC** binding. The use of **SHALL** requires that the component be valued with a member from the cited value set; however, in every case any HL7 "null" value such as other (OTH) or unknown (UNK) may be used.

Each constraint is uniquely identified (e.g., "CONF:605") by an identifier placed at or near the end of the constraint. These identifiers are not sequential as they are based on the order of creation of the constraint.

1. **SHALL** contain [1..1] component/structuredBody (CONF:4082).
    a. This component/structuredBody **SHOULD** contain [0..1] component (CONF:4130) such that it
        a. **SHALL** contain [1..1] Reporting Parameters section (templateId:2.16.840.1.113883.10.20.17.2.1) (CONF:4131).
    b. This component/structuredBody **SHALL** contain [1..1] component (CONF:4132) such that it
        a. **SHALL** contain [1..1] Patient data section - NCR (templateId:2.16.840.1.113883.10.20.17.2.5) (CONF:4133).

Figure 2: Template-based conformance statements example

CCD templates are included within this implementation guide for ease of reference. CCD templates contained within this implementation guide are formatted WITHOUT typical **KEYWORD** and **XML** element styles. A WIKI site is available if you would like to make a comment to be considered for the next release of CCD: *http://wiki.hl7.org/index.php?title=CCD_Suggested_Enhancements* The user name and password are: wiki/wikiwiki. You will need to create an account to edit the page and add your suggestion.

1. The value for "Observation / @moodCode" in a problem observation SHALL be "EVN" 2.16.840.1.113883.5.1001 ActMood STATIC. (CONF: 814).
2. A problem observation SHALL include exactly one Observation / statusCode. (CONF: 815).
3. The value for "Observation / statusCode" in a problem observation SHALL be "completed" 2.16.840.1.113883.5.14 ActStatus STATIC. (CONF: 816).
4. A problem observation SHOULD contain exactly one Observation / effectiveTime, to indicate the biological timing of condition (e.g. the time the condition started, the onset of the illness or symptom, the duration of a condition). (CONF: 817).

Figure 3: CCD conformance statements example

Keywords

The keywords SHALL, SHALL NOT, SHOULD, SHOULD NOT, MAY, and NEED NOT in this document are to be interpreted as described in the *HL7 Version 3 Publishing Facilitator's Guide*:

- **SHALL**: an absolute requirement
- **SHALL NOT**: an absolute prohibition against inclusion
- **SHOULD/SHOULD NOT**: valid reasons to include or ignore a particular item, but must be understood and carefully weighed
- **MAY/NEED NOT**: truly optional; can be included or omitted as the author decides with no implications

XML Examples

XML samples appear in various figures in this document in a fixed-width font. Portions of the XML content may be omitted from the content for brevity, marked by an ellipsis (…) as shown in the example below.

```
<ClinicalDocument xmlns=’urn:h17-org:v3’>
  ...
</ClinicalDocument>
```

Figure 4: ClinicalDocument example

XPath expressions are used in the narrative and conformance requirements to identify elements because they are familiar to many XML implementers.

Chapter 2

DOCUMENT TEMPLATES

Topics:

- *Consultation Request*
- *Consultation Summary*
- *Discharge Instructions*
- *Discharge Summary*

This section contains the document level constraints for CDA documents that are compliant with this implementation guide.

Consultation Request

[ClinicalDocument: templateId `2.16.840.1.113883.3.1275.1.1.4.1`]

1. **SHALL** conform to *Consol General Header Constraints* template (templateId: `2.16.840.1.113883.10.20.22.1.1`)
2. **SHALL** contain exactly one [1..1] **`allergiesSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Allergies Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.6`)
3. **MAY** contain zero or one [0..1] **`assessmentAndPlanSection`**
   a. Contains exactly one [1..1] *Consol Assessment And Plan Section* (templateId: `2.16.840.1.113883.10.20.22.2.9`)
4. **MAY** contain zero or one [0..1] **`historyOfPresentIllnessSection`**
   a. Contains exactly one [1..1] *Consol History Of Present Illness Section* (templateId: `1.3.6.1.4.1.19376.1.5.3.1.3.4`)
5. **MAY** contain zero or one [0..1] **`physicalExamSection`**
   a. Contains exactly one [1..1] *Consol Physical Exam Section* (templateId: `2.16.840.1.113883.10.20.2.10`)
6. **MAY** contain zero or one [0..1] **`reasonForReferralSection`**
   a. Contains exactly one [1..1] *Consol Reason For Referral Section* (templateId: `1.3.6.1.4.1.19376.1.5.3.1.3.1`)
7. **SHALL** contain exactly one [1..1] **`medicationsSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Medications Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.1`)
8. **SHALL** contain exactly one [1..1] **`problemSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Problem Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.5`)
9. **SHALL** contain exactly one [1..1] **`proceduresSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Procedures Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.7`)
10. **SHALL** contain exactly one [1..1] **`resultsSectionEntriesOptional`**
    a. Contains exactly one [1..1] *Consol Results Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.3`)
11. **SHALL** contain exactly one [1..1] **`advanceDirectivesSectionEntriesOptional`**
    a. Contains exactly one [1..1] *Consol Advance Directives Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.21`)
12. **MAY** contain zero or one [0..1] **`encountersSectionEntriesOptional`**
    a. Contains exactly one [1..1] *Consol Encounters Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.22`)
13. **MAY** contain zero or one [0..1] **`familyHistorySection`**
    a. Contains exactly one [1..1] *Consol Family History Section* (templateId: `2.16.840.1.113883.10.20.22.2.15`)
14. **MAY** contain zero or one [0..1] **`functionalStatusSection`**
    a. Contains exactly one [1..1] *Consol Functional Status Section* (templateId: `2.16.840.1.113883.10.20.22.2.14`)
15. **MAY** contain zero or one [0..1] **`immunizationsSectionEntriesOptional`**

   a. Contains exactly one [1..1] *Consol Immunizations Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.2`)
16. **MAY** contain zero or one [0..1] **`medicalEquipmentSection`**
   a. Contains exactly one [1..1] *Consol Medical Equipment Section* (templateId: `2.16.840.1.113883.10.20.22.2.23`)
17. **MAY** contain zero or one [0..1] **`planOfCareSection`**
   a. Contains exactly one [1..1] *Consol Plan Of Care Section* (templateId: `2.16.840.1.113883.10.20.22.2.10`)
18. **MAY** contain zero or one [0..1] **`socialHistorySection`**
   a. Contains exactly one [1..1] *Consol Social History Section* (templateId: `2.16.840.1.113883.10.20.22.2.17`)
19. **MAY** contain zero or one [0..1] **`vitalSignsSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Vital Signs Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.4`)
20. **MAY** contain zero or one [0..1] **`chiefComplaintSection`**
   a. Contains exactly one [1..1] *Consol Chief Complaint Section* (templateId: `1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1`)
21. **MAY** contain zero or one [0..1] **`chiefComplaintAndReasonForVisitSection`**
   a. Contains exactly one [1..1] *Consol Chief Complaint And Reason For Visit Section* (templateId: `2.16.840.1.113883.10.20.22.2.13`)
22. **MAY** contain zero or one [0..1] **`generalStatusSection`**
   a. Contains exactly one [1..1] *Consol General Status Section* (templateId: `2.16.840.1.113883.10.20.2.5`)
23. **MAY** contain zero or one [0..1] **`historyOfPastIllnessSection`**
   a. Contains exactly one [1..1] *Consol History Of Past Illness Section* (templateId: `2.16.840.1.113883.10.20.22.2.20`)
24. **MAY** contain zero or one [0..1] **`payersSection`**
   a. Contains exactly one [1..1] *Consol Payers Section* (templateId: `2.16.840.1.113883.10.20.22.2.18`)

Consultation Request example

Consultation Summary

[ClinicalDocument: templateId `2.16.840.1.113883.3.1275.1.1.3.1`]

1. **SHALL** conform to *Consol General Header Constraints* template (templateId: `2.16.840.1.113883.10.20.22.1.1`)
2. **SHALL** contain exactly one [1..1] **`allergiesSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Allergies Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.6`)
3. **SHALL** contain exactly one [1..1] **`medicationsSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Medications Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.1`)
4. **SHALL** contain exactly one [1..1] **`problemSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Problem Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.5`)

5. **SHALL** contain exactly one [1..1] **`resultsSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Results Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.3`)
6. **MAY** contain zero or one [0..1] **`advanceDirectivesSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Advance Directives Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.21`)
7. **MAY** contain zero or one [0..1] **`encountersSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Encounters Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.22`)
8. **MAY** contain zero or one [0..1] **`familyHistorySection`**
   a. Contains exactly one [1..1] *Consol Family History Section* (templateId: `2.16.840.1.113883.10.20.22.2.15`)
9. **MAY** contain zero or one [0..1] **`functionalStatusSection`**
   a. Contains exactly one [1..1] *Consol Functional Status Section* (templateId: `2.16.840.1.113883.10.20.22.2.14`)
10. **MAY** contain zero or one [0..1] **`immunizationsSectionEntriesOptional`**
    a. Contains exactly one [1..1] *Consol Immunizations Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.2`)
11. **SHALL** contain exactly one [1..1] **`proceduresSectionEntriesOptional`**
    a. Contains exactly one [1..1] *Consol Procedures Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.7`)
12. **MAY** contain zero or one [0..1] **`medicalEquipmentSection`**
    a. Contains exactly one [1..1] *Consol Medical Equipment Section* (templateId: `2.16.840.1.113883.10.20.22.2.23`)
13. **MAY** contain zero or one [0..1] **`payersSection`**
    a. Contains exactly one [1..1] *Consol Payers Section* (templateId: `2.16.840.1.113883.10.20.22.2.18`)
14. **MAY** contain zero or one [0..1] **`planOfCareSection`**
    a. Contains exactly one [1..1] *Consol Plan Of Care Section* (templateId: `2.16.840.1.113883.10.20.22.2.10`)
15. **MAY** contain zero or one [0..1] **`socialHistorySection`**
    a. Contains exactly one [1..1] *Consol Social History Section* (templateId: `2.16.840.1.113883.10.20.22.2.17`)
16. **MAY** contain zero or one [0..1] **`vitalSignsSectionEntriesOptional`**
    a. Contains exactly one [1..1] *Consol Vital Signs Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.4`)

Consultation Summary example

Discharge Instructions

[ClinicalDocument: templateId `2.16.840.1.113883.3.1275.1.1.2.1`]

1. **SHALL** conform to *Consol General Header Constraints* template (templateId: `2.16.840.1.113883.10.20.22.1.1`)
2. **SHALL** contain exactly one [1..1] **`planOfCareSection`**
   a. Contains exactly one [1..1] *Consol Plan Of Care Section* (templateId: `2.16.840.1.113883.10.20.22.2.10`)

3. **SHALL** contain exactly one [1..1] **`allergiesSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Allergies Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.6`)
4. **SHALL** contain exactly one [1..1] **`problemSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Problem Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.5`)
5. **SHALL** contain exactly one [1..1] **`hospitalDischargeMedicationsSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Hospital Discharge Medications Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.11`)
6. **SHALL** contain exactly one [1..1] **`advanceDirectivesSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Advance Directives Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.21`)
7. **SHALL** contain exactly one [1..1] **`immunizationsSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Immunizations Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.2`)
8. **SHALL** contain exactly one [1..1] **`medicalEquipmentSection`**
   a. Contains exactly one [1..1] *Consol Medical Equipment Section* (templateId: `2.16.840.1.113883.10.20.22.2.23`)

Discharge Instructions example

Discharge Summary

[ClinicalDocument: templateId `2.16.840.1.113883.3.1275.1.1.1.1`]

1. **SHALL** conform to *Consol General Header Constraints* template (templateId: `2.16.840.1.113883.10.20.22.1.1`)
2. **SHALL** contain exactly one [1..1] **`allergiesSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Allergies Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.6`)
3. **SHALL** contain exactly one [1..1] **`hospitalCourseSection`**
   a. Contains exactly one [1..1] *Consol Hospital Course Section* (templateId: `1.3.6.1.4.1.19376.1.5.3.1.3.5`)
4. **SHALL** contain exactly one [1..1] **`hospitalDischargeDiagnosisSection`**
   a. Contains exactly one [1..1] *Consol Hospital Discharge Diagnosis Section* (templateId: `2.16.840.1.113883.10.20.22.2.24`)
5. **SHALL** contain exactly one [1..1] **`hospitalDischargeMedicationsSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Hospital Discharge Medications Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.11`)
6. **SHALL** contain exactly one [1..1] **`planOfCareSection`**
   a. Contains exactly one [1..1] *Consol Plan Of Care Section* (templateId: `2.16.840.1.113883.10.20.22.2.10`)
7. **SHALL** contain exactly one [1..1] **`problemSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Problem Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.5`)
8. **MAY** contain zero or one [0..1] **`chiefComplaintSection`**

   a. Contains exactly one [1..1] *Consol Chief Complaint Section* (templateId: `1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1`)
9. **MAY** contain zero or one [0..1] **`chiefComplaintAndReasonForVisitSection`**
   a. Contains exactly one [1..1] *Consol Chief Complaint And Reason For Visit Section* (templateId: `2.16.840.1.113883.10.20.22.2.13`)
10. **MAY** contain zero or one [0..1] **`dischargeDietSection`**
   a. Contains exactly one [1..1] *Consol Discharge Diet Section* (templateId: `1.3.6.1.4.1.19376.1.5.3.1.3.33`)
11. **MAY** contain zero or one [0..1] **`familyHistorySection`**
   a. Contains exactly one [1..1] *Consol Family History Section* (templateId: `2.16.840.1.113883.10.20.22.2.15`)
12. **MAY** contain zero or one [0..1] **`functionalStatusSection`**
   a. Contains exactly one [1..1] *Consol Functional Status Section* (templateId: `2.16.840.1.113883.10.20.22.2.14`)
13. **MAY** contain zero or one [0..1] **`historyOfPresentIllnessSection`**
   a. Contains exactly one [1..1] *Consol History Of Present Illness Section* (templateId: `1.3.6.1.4.1.19376.1.5.3.1.3.4`)
14. **MAY** contain zero or one [0..1] **`hospitalDischargePhysicalSection`**
   a. Contains exactly one [1..1] *Consol Hospital Discharge Physical Section* (templateId: `1.3.6.1.4.1.19376.1.5.3.1.3.26`)
15. **MAY** contain zero or one [0..1] **`hospitalDischargeStudiesSummarySection`**
   a. Contains exactly one [1..1] *Consol Hospital Discharge Studies Summary Section* (templateId: `2.16.840.1.113883.10.20.22.2.16`)
16. **MAY** contain zero or one [0..1] **`proceduresSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Procedures Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.7`)
17. **MAY** contain zero or one [0..1] **`reasonForVisitSection`**
   a. Contains exactly one [1..1] *Consol Reason For Visit Section* (templateId: `2.16.840.1.113883.10.20.22.2.12`)
18. **MAY** contain zero or one [0..1] **`reviewOfSystemsSection`**
   a. Contains exactly one [1..1] *Consol Review Of Systems Section* (templateId: `1.3.6.1.4.1.19376.1.5.3.1.3.18`)
19. **MAY** contain zero or one [0..1] **`socialHistorySection`**
   a. Contains exactly one [1..1] *Consol Social History Section* (templateId: `2.16.840.1.113883.10.20.22.2.17`)
20. **MAY** contain zero or one [0..1] **`vitalSignsSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Vital Signs Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.4`)
21. **MAY** contain zero or one [0..1] **`immunizationsSectionEntriesOptional`**
   a. Contains exactly one [1..1] *Consol Immunizations Section Entries Optional* (templateId: `2.16.840.1.113883.10.20.22.2.2`)

Discharge Summary example

Chapter 3

SECTION TEMPLATES

Please refer to the HL7 CDA Consolidation Guide DSTU (Dec 2011) for Section template definitions.

Chapter 4

VALUE SETS

Topics:

- *Administrative Gender Code*
- *Administrative Gender (HL7 V3)*
- *Admission Type (NUBC)*
- *Advance Directive Type*
- *Age P Q_ UCUM*
- *Allergy/Adverse Event Type*
- *Basic Confidentiality Kind*
- *Body Site*
- *Confidentiality Code*
- *Consult Document Type*
- *Coverage Type Value Set*
- *DCM*
- *DICOMPurposeOfReference*
- *DIR Document Type Codes*
- *Discharge Summary Document Type Code*
- *Encounter Type*
- *HITSP Problem Status*
- *HL7 Financially Responsible Party Type*
- *HP Document Type*
- *Health Insurance Type*
- *Healthcare Provider Taxonomy*
- *Healthcare Service Location*
- *Ingredient Name*
- *Language*
- *Language Ability Mode*
- *Language Ability Proficiency*
- *Marital Status*
- *Medication Brand Name*
- *Medication Clinical Drug*
- *Medication Drug Class*
- *Medication Fill Status*
- *Medication Product Form*
- *Medication Route FDA*
- *Medication Type*

The following tables summarize the value sets used in this Implementation Guide.

- *Mood Code Evn Int*
- *NUCC Health Care Provider Taxonomy*
- *No Immunization Reason*
- *Observation Interpretation (HL7)*
- *Participationsignature*
- *Patient Education*
- *Personal Relationship Role Type*
- *Problem*
- *Problem Act Status Code*
- *Problem Severity*
- *Problem Type*
- *Procedure Act Status Code*
- *Procedure Note Document Type Codes*
- *Progress Note Document Type Code*
- *Provider Type*
- *Race*
- *Religious Affiliation*
- *Role Code*
- *Severity Observation*
- *Social History Type*
- *Surgical Operation Note Document Type Code*
- *Vaccines administered (CVX)*
- *Vital Sign Result*

Administrative Gender Code

Value Set	AdministrativeGenderCode
Description	The gender of a person used for administrative purposes (as opposed to clinical gender)

Administrative Gender (HL7 V3)

Value Set	Administrative Gender (HL7 V3) - 2.16.840.1.113883.1.11.1

Concept Code	Concept Name	Code System	Description
F			
M			
UN			

Admission Type (NUBC)

Value Set	Admission Type (NUBC) - 2.16.840.1.113883.3.88.12.80.33
Source	National Uniform Billing Committee (NUBC)
Source URL	www.nubc.org
Definition	See (UB-04/NUBC CURRENT UB DATA SPECIFICATIONS MANUAL) UB-04 FL14.
Description	A code indicating the priority of the admission (e.g., Emergency, Urgent, Elective, et cetera).

Advance Directive Type

Value Set	Advance Directive Type - 2.16.840.1.113883.1.11.20.2
Code System	SNOMEDCT - 2.16.840.1.113883.6.96
Version	1
Definition	This identifies the type of the Advance Directive. Uses the AdvanceDirectiveTypeCode vocabulary defined by CCD.

Concept Code	Concept Name	Code System	Description
281789004	Antibiotics	SNOMEDCT	
89666000	CPR	SNOMEDCT	
225204009	IV Fluid and Support	SNOMEDCT	
52765003	Intubation	SNOMEDCT	
78823007	Life Support	SNOMEDCT	

Concept Code	Concept Name	Code System	Description
304251008	Resuscitation	SNOMEDCT	

Age P Q_ UCUM

Value Set	AgePQ_UCUM - 2.16.840.1.113883.11.20.9.21
Code System	UCUM - Unified Code for Units of Measure - 2.16.840.1.113883.6.8
Description	A valueSet of UCUM codes for representing age value units.

Concept Code	Concept Name	Code System	Description
min	Minute	UCUM - Unified Code for Units of Measure	
h	Hour	UCUM - Unified Code for Units of Measure	
d	Day	UCUM - Unified Code for Units of Measure	
wk	Week	UCUM - Unified Code for Units of Measure	
mo	Month	UCUM - Unified Code for Units of Measure	
a	Year	UCUM - Unified Code for Units of Measure	

Allergy/Adverse Event Type

Value Set	Allergy/Adverse Event Type - 2.16.840.1.113883.3.88.12.3221.6.2
Code System	SNOMEDCT - 2.16.840.1.113883.6.96

Description	This describes the type of product and intolerance suffered by the patient http://phinvads.cdc.gov/vads/ViewValueSet.action?id=7AFDBFB5-A277-DE11-9B52-0015173D1785

Concept Code	Concept Name	Code System	Description
420134006	Propensity to adverse reactions	SNOMEDCT	
418038007	Propensity to adverse reactions to substance	SNOMEDCT	
419511003	Propensity to adverse reactions to drug	SNOMEDCT	
418471000	Propensity to adverse reactions to food	SNOMEDCT	
419199007	Allergy to substance	SNOMEDCT	
416098002	Drug allergy	SNOMEDCT	
414285001	Food allergy	SNOMEDCT	
59037007	Drug intolerance	SNOMEDCT	
235719002	Food intolerance	SNOMEDCT	

Basic Confidentiality Kind

Value Set	BasicConfidentialityKind - 2.16.840.1.113883.1.11.16926
Code System	ConfidentialityCode - 2.16.840.1.113883.5.25
Source	HL7

Body Site

Value Set	Body Site - 2.16.840.1.113883.3.88.12.3221.8.9
Code System	SNOMEDCT - 2.16.840.1.113883.6.96
Version	2
Definition	Body site value set is based upon the concepts descending from the SNOMED CT Anatomical Structure (91723000) hierarchy.

Confidentiality Code

Value Set	ConfidentialityCode

Consult Document Type

Value Set	ConsultDocumentType - 2.16.840.1.113883.11.20.9.31
Code System	LOINC - 2.16.840.1.113883.6.1

Coverage Type Value Set

Value Set	Coverage Type Value Set - 2.16.840.1.113883.1.11.18877
Code System	RoleCode - 2.16.840.1.113883.5.111
Version	1.0

Concept Code	Concept Name	Code System	Description
FAMDEP	Family dependent	RoleCode	
FSTUD	Full-time student	RoleCode	
HANDIC	Handicapped dependent	RoleCode	
INJ	Injured plaintiff	RoleCode	
PSTUD	Part-time student	RoleCode	
SELF	Self	RoleCode	
SPON		RoleCode	
STUD	Student	RoleCode	

DCM

Value Set	DCM

DICOMPurposeOfReference

Value Set	DICOMPurposeOfReference - 2.16.840.1.113883.11.20.9.28
Code System	DCM - 1.2.840.10008.2.16.4

DIR Document Type Codes

Value Set	DIRDocumentTypeCodes - 2.16.840.1.113883.11.20.9.32
Code System	LOINC - 2.16.840.1.113883.6.1

Discharge Summary Document Type Code

Value Set	DischargeSummaryDocumentTypeCode - 2.16.840.1.113883.11.20.4.1
Code System	LOINC - 2.16.840.1.113883.6.1

Encounter Type

Value Set	EncounterType - 2.16.840.1.113883.3.88.12.80.32

Code System	CPT-4 - 2.16.840.1.113883.6.12
Version	20081218
Source	HITSP
Definition	This value set includes only the codes of the Current Procedure and Terminology designated for Evaluation and Management (99200 - 99299).
Description	This is used to identify medical services and procedures furnished by physicians and other healthcare professionals.

HITSP Problem Status

Value Set	HITSP Problem Status - 2.16.840.1.113883.3.88.12.80.68
Code System	SNOMEDCT - 2.16.840.1.113883.6.96

Concept Code	Concept Name	Code System	Description
55561003	Active	SNOMEDCT	
73425007	Inactive	SNOMEDCT	An inactive problems refers to one that is quiescent, and may appear again in future.
413322009	Resolved	SNOMEDCT	A resolved problem refers to one that used to affect a patient, but does not any more.

HL7 Financially Responsible Party Type

Value Set	HL7FinanciallyResponsiblePartyType - 2.16.840.1.113883.1.11.10416
Code System	HL7RoleClass - 2.16.840.1.113883.5.110

HP Document Type

Value Set	HPDocumentType - 3. 2.16.840.1.113883.1.11.20.22
Code System	LOINC - 2.16.840.1.113883.6.1

Health Insurance Type

Value Set	Health Insurance Type - 2.16.840.1.113883.3.88.12.3221.5.2
Code System	LOINC - 2.16.840.1.113883.6.1
Version	20081218
Source	HITSP
Definition	This value set uses the ACS X12 vocabulary for Insurance Type Code (ASC X12 Data Element 1336) and has been limited by HITSP to the value set reproduced below in Table 2-52 Health Insurance Type Value Set Definition The type of health plan covering the individual, e.g., an HMO, PPO, POS, etc.

Concept Code	Concept Name	Code System	Description
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan	LOINC	
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan	LOINC	
14	Medicare Secondary, No-fault Insurance including Auto is Primary	LOINC	
15	Medicare Secondary Worker's Compensation	LOINC	
16	Medicare Secondary Public Health Service (PHS)or Other Federal Agency	LOINC	
41	Medicare Secondary Black Lung	LOINC	
42	Medicare Secondary Veteran's Administration	LOINC	
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)	LOINC	
47	Medicare Secondary, Other Liability Insurance is Primary	LOINC	
AP	Auto Insurance Policy	LOINC	
C1	Commercial	LOINC	
CO	Consolidated Omnibus Budget Reconciliation Act (COBRA)	LOINC	
CP	Medicare Conditionally Primary	LOINC	
D	Disability	LOINC	
DB	Disability Benefits	LOINC	
EP	Exclusive Provider Organization	LOINC	
FF	Family or Friends	LOINC	

Concept Code	Concept Name	Code System	Description
GP	Group Policy	LOINC	
HM	Health Maintenance Organization (HMO)	LOINC	
HN	Health Maintenance Organization (HMO) - Medicare Risk	LOINC	
HS	Special Low Income Medicare Beneficiary	LOINC	
IN	Indemnity	LOINC	
IP	Individual Policy	LOINC	
LC	Long Term Care	LOINC	
LD	Long Term Policy	LOINC	
LI	Life Insurance	LOINC	
LT	Litigation	LOINC	
MA	Medicare Part A	LOINC	
MB	Medicare Part B	LOINC	
MC	Medicaid	LOINC	
MH	Medigap Part A	LOINC	
MI	Medigap Part B	LOINC	
MP	Medicare Primary	LOINC	
OT	Other	LOINC	
PE	Property Insurance - Personal	LOINC	
PL	Personal	LOINC	
PP	Personal Payment (Cash - No Insurance)	LOINC	
PR	Preferred Provider Organization (PPO)	LOINC	
PS	Point of Service (POS)	LOINC	
QM	Qualified Medicare Beneficiary	LOINC	
RP	Property Insurance - Real	LOINC	
SP	Supplemental Policy	LOINC	
TF	Tax Equity Fiscal Responsibility Act (TEFRA)	LOINC	
WC	Workers Compensation	LOINC	
WU	Wrap Up Policy	LOINC	

Healthcare Provider Taxonomy

Value Set	HealthcareProviderTaxonomy - 2.16.840.1.114222.4.11.1066
Code System	NUCCHealthCareProviderTaxonomy - 2.16.840.1.113883.6.101

Healthcare Service Location

Value Set	HealthcareServiceLocation - 2.16.840.1.113883.1.11.20275
Code System	LOINC - 2.16.840.1.113883.6.1

Ingredient Name

Value Set	Ingredient Name - 2.16.840.1.113883.3.88.12.80.20
Code System	Unique Ingredient Identifier (UNII) - 2.16.840.1.113883.4.9
Description	Unique ingredient identifiers (UNIIs) for substances in drugs, biologics, foods, and devices. http://www.fda.gov/ForIndustry/DataStandards/StructuredProductLabeling/ucm162523.htm

Language

Value Set	Language - 2.16.840.1.113883.1.11.11526
Code System	LOINC - 2.16.840.1.113883.6.1
Version	200609
Source	The Internet Society
Source URL	http://www.ietf.org/rfc/rfc4646.txt
Definition	The value set is defined by Internet RFC 4646 (replacing RFC 3066). Please see ISO 639 language code set maintained by Library of Congress for enumeration of language codes and Frequently Asked Questions.

Language Ability Mode

Value Set	LanguageAbilityMode - 2.16.840.1.113883.1.11.12249
Code System	LanguageAbilityMode - 2.16.840.1.113883.5.60
Version	1
Definition	This identifies the language ability of the individual. A value representing the method of expression of the language.

Concept Code	Concept Name	Code System	Description
ESGN	Expressed signed	LanguageAbilityMode	
ESP	Expressed spoken	LanguageAbilityMode	

Concept Code	Concept Name	Code System	Description
EWR	Expressed written	LanguageAbilityMode	
RSGN	Received signed	LanguageAbilityMode	
RSP	Received spoken	LanguageAbilityMode	
RWR	Received written	LanguageAbilityMode	

Language Ability Proficiency

Value Set	LanguageAbilityProficiency - 2.16.840.1.113883.1.11.12199
Code System	LanguageAbilityProficiency - 2.16.840.1.113883.5.61

Concept Code	Concept Name	Code System	Description
E	Excellent	LanguageAbilityProficiency	
F	Fair	LanguageAbilityProficiency	
G	Good	LanguageAbilityProficiency	
P	Poor	LanguageAbilityProficiency	

Marital Status

Value Set	Marital Status - 2.16.840.1.113883.1.11.12212
Code System	MaritalStatus - 2.16.840.1.113883.5.2
Version	1
Definition	Marital Status is the domestic partnership status of a person.

Concept Code	Concept Name	Code System	Description
A		MaritalStatus	
D		MaritalStatus	
T		MaritalStatus	
I		MaritalStatus	
L		MaritalStatus	
M		MaritalStatus	
S		MaritalStatus	
P		MaritalStatus	
W		MaritalStatus	

Medication Brand Name

Value Set	Medication Brand Name - 2.16.840.1.113883.3.88.12.80.16

Code System	RxNorm - 2.16.840.1.113883.6.88
Description	Brand names http://phinvads.cdc.gov/vads/ViewValueSet.action?id=229BEF3E-971C-DF11-B334-0015173D1785

Medication Clinical Drug

Value Set	Medication Clinical Drug - 2.16.840.1.113883.3.88.12.80.17
Code System	RxNorm - 2.16.840.1.113883.6.88
Description	Clinical drug names http://phinvads.cdc.gov/vads/ViewValueSet.action?id=239BEF3E-971C-DF11-B334-0015173D1785

Medication Drug Class

Value Set	Medication Drug Class - 2.16.840.1.113883.3.88.12.80.18
Description	This identifies the pharmacological drug class, such as Cephalosporins. Shall contain a value descending from the NDF-RT concept types of "Mechanism of Action - N0000000223", "Physiologic Effect - N0000009802" or "Chemical Structure - N0000000002". NUI will be used as the concept code. http://phinvads.cdc.gov/vads/ViewValueSet.action?id=77FDBFB5-A277-DE11-9B52-0015173D1785

Medication Fill Status

Value Set	Medication Fill Status - 2.16.840.1.113883.3.88.12.80.64
Code System	ActStatus - 2.16.840.1.113883.5.14
Version	1
Definition	The HL7 ActStatus has been limited by HITSP. This identifies whether the medication has been fulfilled, such as completed and aborted

Concept Code	Concept Name	Code System	Description
aborted	Aborted	ActStatus	
completed	Completed	ActStatus	

Medication Product Form

Value Set	Medication Product Form - 2.16.840.1.113883.3.88.12.3221.8.11
Code System	NCI Thesaurus - 2.16.840.1.113883.3.26.1.1
Version	1
Definition	This is the physical form of the product as presented to the individual. For example: tablet, capsule, liquid or ointment. NCI concept code for pharmaceutical dosage form: C42636

Medication Route FDA

Value Set	Medication Route FDA - 2.16.840.1.113883.3.88.12.3221.8.7
Code System	NCI Thesaurus - 2.16.840.1.113883.3.26.1.1
Version	1
Definition	Route of Administration value set is based upon FDA Drug Registration and Listing Database (FDA Orange Book) which are used in FDA structured product and labelling (SPL).

Medication Type

Value Set	Medication Type - 2.16.840.1.113883.3.88.12.3221.8.19
Code System	SNOMEDCT - 2.16.840.1.113883.6.96
Version	1
Definition	This is a classification based on how the medication is marketed (e.g., prescription, over the counter drug)

Concept Code	Concept Name	Code System	Description
329505003	Over the counter products	SNOMEDCT	
73639000	Prescription Drug	SNOMEDCT	

Mood Code Evn Int

Value Set	MoodCodeEvnInt - 2.16.840.1.113883.11.20.9.18
Code System	HL7ActMood - 2.16.840.1.113883.5.1001
Version	2011-04-03
Definition	Subset of HL7 ActMood codes, constrained to represent event (EVN) and intent (INT) moodes

Concept Code	Concept Name	Code System	Description
EVN	Event	HL7ActMood	
INT	Intent	HL7ActMood	

NUCC Health Care Provider Taxonomy

Value Set	NUCCHealthCareProviderTaxonomy

No Immunization Reason

Value Set	No Immunization Reason - 2.16.840.1.113883.1.11.19717
Code System	ActReason - 2.16.840.1.113883.5.8
Version	1
Source	
Definition	This identifies the reason why the immunization did not occur

Concept Code	Concept Name	Code System	Description
IMMUNE	Immunity	ActReason	
MEDPREC	medical precaution	ActReason	
OSTOCK	Out of stock	ActReason	
PATOBJ	patient objection	ActReason	
PHILISOP	philosophical objection	ActReason	
RELIG	religious objection	ActReason	
VACEFF	vaccine efficacy concerns	ActReason	
VACSAF	vaccine safety concerns	ActReason	

Observation Interpretation (HL7)

Value Set	Observation Interpretation (HL7) - 2.16.840.1.113883.1.11.78

Participationsignature

Value Set	Participationsignature

Patient Education

Value Set	PatientEducation - 4. 2.16.840.1.113883.11.20.9.34

Personal Relationship Role Type

Value Set	Personal Relationship Role Type - 2.16.840.1.113883.1.11.19563
Code System	RoleCode - 2.16.840.1.113883.5.111
Version	1
Definition	A Personal Relationship records the role of a person in relation to another person. This value set is to be used when recording the relationships between different people who are not necessarily related by family ties, but also includes family relationships

Concept Code	Concept Name	Code System	Description
ADOPT	adopted child	RoleCode	
AUNT	aunt	RoleCode	
CHILD	Child	RoleCode	
CHLDINLAW	child in-law	RoleCode	
COUSN	cousin	RoleCode	
DOMPART	domestic partner	RoleCode	
FAMMEMB	Family Member	RoleCode	
CHLDFOST	foster child	RoleCode	
GRNDCHILD	grandchild	RoleCode	
GPARNT	grandparent	RoleCode	
GRPRN	Grandparent	RoleCode	
GGRPRN	great grandparent	RoleCode	
HSIB	half-sibling	RoleCode	
MAUNT	MaternalAunt	RoleCode	
MCOUSN	MaternalCousin	RoleCode	
MGRPRN	MaternalGrandparent	RoleCode	
MGGRPRN	MaternalGreatgrandparent	RoleCode	
MUNCLE	MaternalUncle	RoleCode	
NCHILD	natural child	RoleCode	
NPRN	natural parent	RoleCode	
NSIB	natural sibling	RoleCode	
NBOR	neighbor	RoleCode	
NIENEPH	niece/nephew	RoleCode	
PRN	Parent	RoleCode	
PRNINLAW	parent in-law	RoleCode	
PAUNT	PaternalAunt	RoleCode	
PCOUSN	PaternalCousin	RoleCode	
PGRPRN	PaternalGrandparent	RoleCode	
PGGRPRN	PaternalGreatgrandparent	RoleCode	
PUNCLE	PaternalUncle	RoleCode	
ROOM	Roommate	RoleCode	
SIB	Sibling	RoleCode	
SIBINLAW	sibling in-law	RoleCode	
SIGOTHR	significant other	RoleCode	
SPS	spouse	RoleCode	

Concept Code	Concept Name	Code System	Description
STEP	step child	RoleCode	
STPPRN	step parent	RoleCode	
STPSIB	step sibling	RoleCode	
UNCLE	uncle	RoleCode	
FRND	unrelated friend	RoleCode	

Problem

Value Set	Problem - 2.16.840.1.113883.3.88.12.3221.7.4
Code System	SNOMEDCT - 2.16.840.1.113883.6.96
Version	DYNAMIC
Source	http://phinvads.cdc.gov/vads/ViewValueSet.action?id=70FDBFB5-A277-DE11-9B52-0015173D1785
Description	Problems and diagnoses. Limited to terms decending from the Clinical Findings (404684003) or Situation with Explicit Context (243796009) hierarchies.

Problem Act Status Code

Value Set	ProblemActStatusCode - 2.16.840.1.113883.11.20.9.19
Code System	ActStatus - 2.16.840.1.113883.5.14
Version	2011-09-09
Description	This value set indicates the status of the problem concern act.

Concept Code	Concept Name	Code System	Description
active		ActStatus	
suspended		ActStatus	
aborted		ActStatus	
completed		ActStatus	

Problem Severity

Value Set	Problem Severity - 2.16.840.1.113883.3.88.12.3221.6.8
Code System	SNOMEDCT - 2.16.840.1.113883.6.96
Description	This is a description of the level of the severity of the problem.

Concept Code	Concept Name	Code System	Description
255604002	Mild	SNOMEDCT	

Concept Code	Concept Name	Code System	Description
371923003	Mild to moderate	SNOMEDCT	
6736007	Moderate	SNOMEDCT	
371924009	Moderate to severe	SNOMEDCT	
24484000	Severe	SNOMEDCT	
399166001	Fatal	SNOMEDCT	

Problem Type

Value Set	Problem Type - 2.16.840.1.113883.3.88.12.3221.7.2
Code System	SNOMEDCT - 2.16.840.1.113883.6.96
Version	2008-12-18
Description	This value set indicates the level of medical judgment used to determine the existence of a problem.

Concept Code	Concept Name	Code System	Description
404684003	Finding	SNOMEDCT	
409586006	Complaint	SNOMEDCT	
282291009	Diagnosis	SNOMEDCT	
64572001	Condition	SNOMEDCT	
248536006	Functional limitation	SNOMEDCT	
418799008	Symptom	SNOMEDCT	
55607006	Problem	SNOMEDCT	

Procedure Act Status Code

Value Set	ProcedureActStatusCode - 2.16.840.1.113883.11.20.9.22
Code System	ActStatus - 2.16.840.1.113883.5.14
Definition	A ValueSet of HL7 actStatus codes for use with a procedure activity

Concept Code	Concept Name	Code System	Description
completed	Completed	ActStatus	
active	Active	ActStatus	
aborted	Aborted	ActStatus	
cancelled	Cancelled	ActStatus	

Procedure Note Document Type Codes

Value Set	ProcedureNoteDocumentTypeCodes - 2.16.840.1.113883.11.20.6.1
Code System	LOINC - 2.16.840.1.113883.6.1

Progress Note Document Type Code

Value Set	ProgressNoteDocumentTypeCode - 2.16.840.1.113883.11.20.8.1
Code System	LOINC - 2.16.840.1.113883.6.1

Provider Type

Value Set	ProviderType - 2.16.840.1.113883.3.88.12.3221.4
Code System	NUCCHealthCareProviderTaxonomy - 2.16.840.1.113883.6.101
Description	The Provider type vocabulary classifies providers according to the type of license or accreditation they hold or the service they provide.

Race

Value Set	Race - 2.16.840.1.113883.1.11.14914
Code System	Race and Ethnicity - CDC - 2.16.840.1.113883.6.238
Version	1
Definition	A Value Set of codes for Classifying data based upon race. Race is always reported at the discretion of the person for whom this attribute is reported, and reporting must be completed according to Federal guidelines for race reporting. Any code descending from the Race concept (1000-9) in that terminology may be used in the exchange.

Religious Affiliation

Value Set	Religious Affiliation - 2.16.840.1.113883.1.11.19185
Code System	ReligiousAffiliation - 2.16.840.1.113883.5.1076
Version	1
Definition	This reflects the spiritual faith affiliation

Role Code

Value Set	RoleCode - (OID not specified)
Description	Specific classification codes for further qualifying RoleClass codes.

Severity Observation

Value Set	SeverityObservation - (OID not specified)
Code System	SeverityObservation - 2.16.840.1.113883.5.1063

Concept Code	Concept Name	Code System	Description
H	High	SeverityObservation	
M	Moderate	SeverityObservation	
L	Low	SeverityObservation	

Social History Type

Value Set	Social History Type - 2.16.840.1.113883.3.88.12.80.60
Code System	SNOMEDCT - 2.16.840.1.113883.6.96
Version	1
Definition	This indicates the type of social history observation

Concept Code	Concept Name	Code System	Description
160573003	ETOH (Alcohol) Use	SNOMEDCT	
363908000	Drug Use	SNOMEDCT	
364703007	Employment	SNOMEDCT	
256235009	Exercise	SNOMEDCT	
228272008	Other Social History	SNOMEDCT	
364393001	Diet	SNOMEDCT	
229819007	Smoking	SNOMEDCT	
425400000	Toxic Exposure	SNOMEDCT	

Surgical Operation Note Document Type Code

Value Set	SurgicalOperationNoteDocumentTypeCode - (OID not specified)
Code System	LOINC - 2.16.840.1.113883.6.1

Vaccines administered (CVX)

Value Set	Vaccines administered (CVX) - 2.16.840.1.114222.4.11.934
Code System	Vaccines administered (CVX) - 2.16.840.1.113883.6.59
Version	3
Definition	Vaccine Name Keyword: Clinical Vaccines, Vaccine Names

Vital Sign Result

Value Set	Vital Sign Result - 2.16.840.1.113883.3.88.12.80.62
Code System	LOINC - 2.16.840.1.113883.6.1
Version	1
Source	HITSP
Definition	This identifies the vital sign result type

Concept Code	Concept Name	Code System	Description
8310-5	Body temperature:Temp:Pt:^Patient:Qn:	LOINC	
8462-4	Intravascular diastolic:Pres:Pt:Arterial system:Qn:	LOINC	
8480-6	Intravascular systolic:Pres:Pt:Arterial system:Qn:	LOINC	
8287-5	Circumference.occipital-frontal:Len:Pt:Head:Qn:Tape measure	LOINC	
8867-4	Heart beat:NRat:Pt:XXX:Qn:	LOINC	
8302-2	Body height:Len:Pt:^Patient:Qn:	LOINC	
8306-3	Body height^lying:Len:Pt:^Patient:Qn:	LOINC	
2710-2	Oxygen saturation:SFr:Pt:BldC:Qn:Oximetry	LOINC	
9279-1	Breaths:NRat:Pt:Respiratory system:Qn:	LOINC	
3141-9	Body weight:Mass:Pt:^Patient:Qn:Measured	LOINC	

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