**Integrating the Healthcare Enterprise**



**IHE Patient Care Coordination (PCC)**

**Technical Framework Supplement**

**CDA Document Summary Section**

**(CDA-DSS)**

**Revision x.x – Draft in Preparation for Public Comment (*or* Trial Implementation)**

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**Please verify you have the most recent version of this document.** See [here](http://ihe.net/Technical_Frameworks/) for Trial Implementation and Final Text versions and [here](http://ihe.net/Public_Comment/) for Public Comment versions.

<Instructions to authors are encapsulated in angled brackets as “< … >” and denoted with italicized text. These instructions should be deleted entirely prior to publication.>

<Use of capitalization: Please follow standard English grammar rules-only proper nouns and names are upper case. For example, “Modality Actor” is upper case, but “an actor which fulfills the role of a modality” is lower case. Do not use upper case to emphasize a word/topic. Examples:

<Note: Before creating a draft supplement, please review the editing conventions, which include information such as section, table and diagram numbering and how to use Microsoft Word tools, at <http://wiki.ihe.net/index.php?title=Writing_Technical_Frameworks_and_Supplements>. This guidance is especially useful for first time authors.>

<This supplement template is intended for developing new profiles or making significant changes to profiles, such as adding formal options. Simple changes to existing supplements or profiles should be made using the Change Proposal (CP) process. See the Technical Framework Development section at <http://wiki.ihe.net/index.php?title=Process#Technical_Framework_Development> for more guidance on supplements vs. CPs.>

<All of the sections in this document are required. Sections may not be deleted. The outline numbering is intended to be consistent across profiles and across domains, so do not adjust the outline numbering. If there is no relevant content for a section, simply state “Section not applicable”, but leave the numbering intact. Sub-sections may be added for clarity.>

*<This supplement template includes templates for Volumes 1 (Profiles), 2 (Transactions), 3 (Content Modules), and 4 (National Extensions).>*

*<Volumes 1, 2, and/or 3 are developed together for Public Comment and Trial Implementation submission. Volume 4, National Extensions, is typically developed at a later point in time, usually at Trial Implementation or later. Templates for all four volumes are included in this document for the sake of completeness. If you are beginning a new profile, you are strongly discouraged from using National Extensions and should instead focus on optional data sets or other alternatives. For more information, see* [*http://wiki.ihe.net/index.php?title=National\_Extensions\_Process*](http://wiki.ihe.net/index.php?title=National_Extensions_Process)*.>*

**Foreword**

This is a supplement to the IHE <Domain Name> Technical Framework <VX.X>. Each supplement undergoes a process of public comment and trial implementation before being incorporated into the volumes of the Technical Frameworks.

*<For Public Comment:>* This supplement is published on <Month XX, 201x> for Public Comment. Comments are invited and can be submitted at <http://www.ihe.net/Public_Comment/#domainname>. In order to be considered in development of the Trial Implementation version of the supplement, comments must be received by <Month XX, 201X>.

*<For Trial Implementation:>* This supplement is published on <Month XX, 201X> for Trial Implementation and may be available for testing at subsequent IHE Connectathons. The supplement may be amended based on the results of testing. Following successful testing it will be incorporated into the <Domain Name> Technical Framework. Comments are invited and can be submitted at <http://www.ihe.net/Public_Comment/#domainname>.

This supplement describes changes to the existing technical framework documents.

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

Amend section X.X by the following:

Where the amendment adds text, make the added text bold underline. Where the amendment removes text, make the removed text bold strikethrough. When entire new sections are added, introduce with editor’s instructions to “add new text” or similar, which for readability are not bolded or underlined.

General information about IHE can be found at [www.ihe.net](http://www.ihe.net/).

Information about the IHE <Domain Name> domain can be found at [ihe.net/IHE\_Domains](file:///D:\Google%20Drive\01_IHE\AppData\Roaming\Microsoft\Word\ihe.net\IHE_Domains\).

Information about the organization of IHE Technical Frameworks and Supplements and the process used to create them can be found at [http://ihe.net/IHE\_Process](http://ihe.net/IHE_Process/) and [http://ihe.net/Profiles](http://ihe.net/Profiles/).

The current version of the IHE <Domain name>Technical Framework can be found at [http://ihe.net/Technical\_Frameworks](http://ihe.net/Technical_Frameworks/).

*<Comments may be submitted on IHE Technical Framework templates any time at* [*http://ihe.net/Templates\_Public\_Comments*](http://ihe.net/Templates_Public_Comments/)*. Please enter comments/issues as soon as they are found. Do not wait until a future review cycle is announced.>*

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# Introduction to this Supplement

<Provide a brief overview of the volumes/sections of the Technical Framework that get changed/ added by this supplement. Provide 200 words or less describing this supplement.>

Current CDA content profiles do not capture specific summary information about a document based on user need. Nor does it capture summary information about content in varying section(s) that is needed to be communicated to the reader (e.g. provider and/or patient) in a concise way. This profile will provide a way to communicate precise information about a document or section(s) in a useful way.

## Open Issues and Questions

<List the open issues/questions that need to be addressed. These are particularly useful for highlighting problematic issues and/or specifically soliciting public comments.>

1. How should C-CDA templates be handled in this template – Volume 6? Should there be an internationalized template?

## Closed Issues

<List the closed issues/questions with their resolutions. These are particularly useful for recording the rationale for closed issues to forestall unnecessary rehashing in the future and/or to make it easier to identify when a closed issue should be re-opened due to new information.>

# General Introduction and Shared Appendices

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

# Appendix A – Actor Summary Definitions

Add the following actors to the IHE Technical Frameworks General Introduction Appendix A:

No new actor definition

# Appendix B – Transaction Summary Definitions

Add the following transactions to the IHE Technical Frameworks General Introduction Appendix B:

No new transactions

# Appendix D – Glossary

Add the following **new** glossary terms to the IHE Technical Frameworks General Introduction Appendix D.

| Glossary Term | Definition |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |

Volume 1 – Profiles

## Copyright Licenses

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

Not applicable

## Domain-specific additions

None

Add new Section #

*<Reserve a subsequent section number in the current domain Technical Framework Volume 1 (DOM TF-1). Replace the letter “X” with that section heading number. This number should not change when this supplement is added to the Final Text Technical Framework. In this manner, references should be able to be maintained going forward.>*

# X CDA Document Summary Section Profile (CDA-DSS)

<Provide an end-user friendly overview of what the profile does for them. Keep it brief (a paragraph or two, up to a page). If extensive detail is needed, it should be included in Section X.4- Use Cases.>

CDA Document Summary Section is a content profile that defines means of providing a concise summary about a document or summary of content in a CDA document based on user expectations.Depending on use case, a Document Summary Section can be added to a CDA document if the document template is open.

A Document Summary Section can be constructed by:

1. Dynamically populating the section with data found in existing section(s) in the document. The data is used to create a composite, single summary section that summarizes pertinent information. The data that goes in the Summary Section can be user defined or can be based on specified use cases in this profile.
2. Use of a pre-defined section template such as the Notes Section or the Care Team Section, etc.

The Summary Section can be rendered for viewing. It can also be imported when possible (i.e. contains discrete entries) by the user if desired.

## X.1 CDA-DSS Actors, Transactions, and Content Modules

This section defines the actors, transactions, and/or content modules in this profile. General definitions of actors are given in the Technical Frameworks General Introduction Appendix A at [http://www.ihe.net/Technical\_Frameworks](http://www.ihe.net/Technical_Frameworks/) .

Figure X.1-1 shows the actors involved in the Summary Section Integration Profile and the relevant transactions between them.



Figure X.1-1: CDA-DSS Actor Diagram

The CDA-DSS Profile introduces actor options for Content Creator and Content Consumer. These options are used in addition to the Content Creator and Content Consumer Options defined by other Patient Care Coordination profiles.

Table X.1-1 lists the transactions for each actor directly involved in the Summary Section Profile. In order to claim support of this Integration Profile, an implementation must perform the required transactions (labeled “R”). Transactions labeled “O” are optional. A complete list of options defined by this Profile and that implementations may choose to support is listed in Volume 1, Section X.2.

Table X.1-1: Summary Section Integration Profile - Actors and Transactions

|  |  |  |  |
| --- | --- | --- | --- |
| Actors | Transactions | Optionality | Section in TF |
| Content Creator | Share Content [PCC-1] | R | PCC TF-2:3.1 |
| Content Consumer | Share Content [PCC-1] | R | PCC TF-2:3.1 |

Table X.1-2 lists the content module(s) defined in the CDA-DSS Profile. To claim support with this profile, an actor shall support all required content modules (labeled “R”) and may support optional content modules (labeled “O”).

<Note that this table number has to change if this profile describes both transactions and content modules (or there will be two tables entitled X.1-1).>

<Note that the abbreviation in the column “Reference” the letter “D” will be incremented for every content module document defined in this profile (e.g., For example D1, D2).>

<In general, one supplement template will only contain one required content module document, but the example here shows multiple with one optional, just for illustration purposes.>

Table X.1-2 CDA-DSS – Actors and Content Modules

| Actors | Content Modules | Optionality | Reference |
| --- | --- | --- | --- |
| Content Creator | User Defined Summary Section  Template ID 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.11 | O | PCC TF-3: 6.3.1.S |
| Document Summary Section  Template ID 1.3.6.1.4.1.19376.1.4.1.2.16 | O | IHE Card |
| Notes Summary Section  Template ID 2.16.840.1.113883.10.20.22.2.65:2016-11-01 | O | C-CDA notes section |
| Care Plan Summary Section  Template ID 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.8 | O | PCC TF-3: 6.3.3.S |
| Encounter Summary Section  Template ID 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.9 | O | PCC TF-3: 6.3.1.S |
| Care Team Summary Section  Template ID (TBD) | O | C-CDA Care Team |
| Active/Planned Medication Summary Section  Template ID 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.10 | O | PCC TF-3: 6.3.1.S |
| Content Consumer | User Defined Summary Section  Template ID 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.11 | O | PCC TF-3: 6.3.1.S |
| Document Summary Section  Template ID 1.3.6.1.4.1.19376.1.4.1.2.16 | O | IHE Card |
| Notes Summary Section  Template ID 2.16.840.1.113883.10.20.22.2.65:2016-11-01 | O | C-CDA notes section |
| Care Plan Summary Section  Template ID 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.8 | O | PCC TF-3: 6.3.3.S |
| Encounter Summary Section  Template ID 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.9 | O | PCC TF-3: 6.3.1.S |
| Care Team Summary Section  Template ID (TBD) | O | PCC TF-3: 6.3.3.S |
| Active/Planned Medication Summary Section  Template ID 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.10 | O | PCC TF-3: 6.3.1.S |

Note 1: *<For example, a note could describe that one of two possible transactions could be supported by an actor or other variations.*

*For example - Note 1: Either Content Module 2 or Content Module 3 shall be implemented for the Content Creator or Content Consumer.*

*For example- Note 1: At least one of Content Module 2, Content Module 3, or Content Module 4 shall be implemented for Content Consumer.>*

### X.1.1 Actor Descriptions and Actor Profile Requirements

#### X.1.1.1 Content Creator

A Content Creator that supports the CDA-DSS Profile shall support the Summary Section Option. See PCC TF-2: 3.Y.1

1. The Content Creator SHALL create a document with at least one summary section.
2. The Content Creator MAY create content conforming to a profile supporting a Medical Summary as defined in PCC TF-2:6.3.1.2 Medical Summary.
3. The Content Creator MAY create content conforming to a profile supporting a Consolidated CDA Implementation Guide Document.

#### X.1.1.2 Content Consumer

The Content Consumer that supports the CDA-DSS Profile shall support the Summary Section Option. See PCC TF-2: 3.Y.1

1. The Content Consumer SHALL render at least one summary section.
2. The Content Consumer MAY implement a content profile supporting a Medical Summary as defined in PCC TF-2:6.3.1.2 Medical Summary.
3. The Content Consumer MAY implement a content profile supporting documents as defined by C-CDA Implementation Guide

### X.1.2 Content Modules

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

Table X.1.2-1: Summary Section Content Modules

| Content Modules | Optionality | Template ID |
| --- | --- | --- |
| User Defined Summary Section | O – note 1 | 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.11 |
| Document Summary Section | O | 1.3.6.1.4.1.19376.1.4.1.2.16 |
| Notes Section | O | 2.16.840.1.113883.10.20.22.2.65:2016-11-01 |
| Care Plan Summary Section | O – note 1 | 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.8 |
| Encounter Summary Section | O – note 1 | 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.9 |
| Care Team Section | O | TBD (HL7 Template ID) |
| Active/Planned Medication Section | O – note 1 | 1.3.6.1.4.1.19376.1.5.3.1.1.26.1.10 |

Note 1 – Summary section content generated from content in existing sections in the document.

## X.2 CDA-DSS Actor Options

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

Table X.2-1: CDA-DSS – Actors and Options

| Actor | Option Name | Reference |
| --- | --- | --- |
| Content Creator | Summary Section Option | PCC TF- 2: 3.Y.1 |
| Content Consumer | Summary Section Option | PCC TF- 2: 3.Y.2 |

*<Add a sub-section below for every new option defined in Table X.2-1.>*

### X.2.1 Summary Section Option

A Content Creator supporting the Summary Section Option must include Summary Section Content in the document created (see Section 6.3.3.S).

A Content Consumer supporting the Summary Section Option must render Summary Section Content for viewing (see Section 6.3.3.S).

## X.3 CDA-DSS Required Actor Groupings

Table X.3-1: CDA-DSS - Required Actor Groupings

| CDA-DSS Actor | Actor(s) to be grouped with | Reference | Content Bindings Reference |
| --- | --- | --- | --- |
| Content Creator | None | -- | -- |
| Content Consumer | None | -- | -- |

## X.4 CDA-DSS Overview

Providing a concise summary of a document based on specific user expectations can be time saving for a provider. It can also reflect what the patient needs to see in a way that is not too overwhelming. This profile enables the ability to provide relevant and pertinent information in sections that are concise and that support a specific purpose that the sender specifies. This allows the large amount of information in a CDA document to be provided yet at the same time not become overwhelming for the reader of the document.

The definition of a summary section is based on specific use cases. A summary section can be added to a CDA document that is an open template. A summary section can be constructed dynamically or a pre-defined section template can be used.

1. A summary section can be user defined. For example, a user can decide to create a summary section that lists procedures the patient had in the last six months. If the document has sections containing procedures with the relevant procedure dates, the applicable procedures can be rendered in the User Defined Summary Section.
2. A summary section can be a pre-defined section template. For example, the Notes Section and the Care Team Sections are pre-defined HL7 C-CDA section templates. The Document Summary Section is a pre-defined IHE section template.
3. A summary section can be use case defined. For example, the Care Plan Summary Section can be dynamically created based on content from the relevant care plan sections. The applicable content is then rendered in the Care Plan Summary Section as defined by this IHE profile. Figure x-4.1 shows a Care Plan Summary Section in a Care Plan Document.

The following is an example of how care plan content may be represented in a CDA document with a summary section:

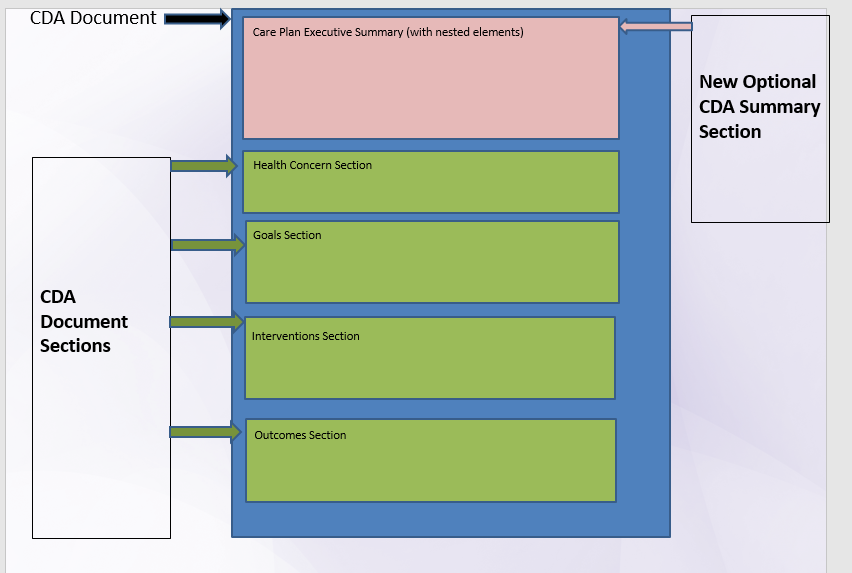


Figure X-4.1: Example of a Care Plan Summary Section

### X.4.1 Concepts

A Summary Section can be generated or added to a CDA document when the document is created. A Summary Section can also be generated and viewed when a CDA document is received.

1. A user can create a User Defined Summary Section based on user defined criteria when a CDA document is received as well as when a CDA document is generated.
2. A user can create a predefined Summary Section based on identified use cases when a CDA document is generated as well as when a CDA document is received.
3. A user can add a predefined summary section template to a document when the document is created.

### X.4.2 Use Cases

#### X.4.2.1 Use Case #1: User Defined Summary Section

This use case involves a Primary Care Physician (PCP) generating a User Defined Summary Section based on content in a CDA document he has received. The information in the User Defined Summary Section can be used to better direct the patient’s care.

##### X.4.2.1.1 User Defined Summary Section Use Case Description

This use case involves a patient being seen by his PCP for an emergency department (ED) follow-up encounter. The patient was seen in the ED recently for complaints of chronic back pain. The PCP has access to the patient’s continuity of care document (CCD) generated at the completion of the ED visit. The following is an example of how the User Defined Summary Section is used. The PCP would like to view a summary section which lists all the ED visits this patient has had in the past six months including the reason for the visit and a list of medications prescribed during each of those ED visits. This may assist the provider in determining if a patient may be demonstrating drug seeking behavior.

##### X.4.2.1.2 User Defined Summary Section Process Flow

ED  
(Content Creator)

Actor E

Actor D/

Actor E

PCP  
(Content Consumer)

Actor B

Actor A /

Actor B

Share Content

Transaction-A [A]

Check for needed information

Generate User Defined Summary Section

Render User Defined Summary Section

Figure X.4.2.1.2-1: Basic Process Flow in CDA-DSS Profile

Pre-conditions:

The ED CCD must contain the information needed to satisfy the user defined preferences that would go in the User Defined Summary Section.

Main Flow:

The content consumer provides the ability to check the CCD for the needed information based on the user defined preference. The user defined preference includes encounters of ED visit type and encounter dates within the past six months. The user preference also includes medication information that is associated with the applicable ED encounters.

Post Conditions:

A User Defined Summary Section is generated containing a list of ED visits in the last six months. Each encounter has the medications prescribed/administered during the encounter.

#### X.4.2.2 Use Case #2: Care Plan Summary Section

This use case involves a Primary Care Physician (PCP) generating and sharing a Care Plan Summary Section based on content in a care plan document. The PCP would like to view the care plan content with its applicable linkages to get a better understanding of the various health concerns that may be related to the same goals along with the applicable interventions. This will help the PCP in understanding which interventions are effective in assisting the patient attain desirable outcomes so that he is better able to direct his patient’s care.

##### X.4.2.2.1 Care Plan Summary Section Use Case Description

This use case involves a patient visiting their Primary Care Physician for a routine visit. The patient arrives at the clinic with a list of health concerns that he wishes to discuss. The patient’s sleep apnea, an existing condition, is getting worse. He has also developed frequent headaches. The PCP makes note of these new health concerns, and performs a physical examination. He notes that the patient’s weight has increased since his last visit, which may be an aggravating factor. They agree to create a new care plan goal to reduce the patient’s weight by ten percent and re-evaluate the condition when that goal has been reached before considering any more invasive treatment. In the meantime, the PCP prescribes an analgesic to help with the headaches.

The PCP produces a care plan document at the end of the visit and shares it with the patient, as he wants to provide his patient with a meaningful recap of what they discussed during the visit. This document contains the health concerns with related goals, interventions and planned interventions as well as outcomes discussed during this visit. The PCP would like for the patient to fully understand the care plan they have agreed on. The care plan includes a Care Plan Summary Section that is shows the care plan content with its applicable linkages.

##### X.4.2.2.2 Care Plan Summary Section Process Flow

Patient Portal  
(Content Consumer)

Actor E

Actor D/

Actor E

PCP  
(Content Creator)

Actor B

Actor A /

Actor B

Share Content

Transaction-A [A]

Check for needed information

Generate Care Plan Summary Section

Share CDA document

Figure X.4.2.1.2-1: Basic Process Flow in CDA-DSS Profile

Pre-conditions:

The PCP care plan document must contain the information needed to satisfy the Care Plan Summary Section rendering.

Main Flow:

The content creator provides the ability to check the care plan document for the information needed to create the care plan summary section. At a minimal, the care plan document includes a health concern section with health concerns linked to the applicable goal(s). The goal references and is referenced by content in the interventions section. The interventions are referenced by content in the health status and evaluation section.

Post Conditions:

A Care Plan Summary Section is generated containing the care plan document components showing the relevant linkages. The document containing the Care Plan Summary Section is shared with the patient.

#### X.4.2.3 Use Case #3: Encounter Summary Section

This use case involves a Primary Care Physician (PCP) generating and sharing specific information that was discussed, planned and accomplished during a specific encounter. An Encounter Summary Section is based on content in an encounter based CDA document that is concise and is provided to the patient as a reminder or to assist the patient in keeping abreast of specifics of an encounter. This will assist the PCP better direct the patient’s care and supports the patient’s engagement in his care.

##### X.4.2.3.1 Encounter Summary Section Use Case Description

This use case involves a patient visiting his Primary Care Physician for a routine visit. The patient arrives at the clinic with a list of problems that he wishes to discuss. The patient’s joint pain, an existing condition, is getting worse. He has also developed frequent heartburn. The PCP makes note of these new problems, and performs a physical examination. He notes that the patient’s weight has decreased since his last visit, which may be due to decrease appetite related to his heartburn complaint. The PCP refers the patient to an ear, nose and throat (ENT) specialist. In the meantime, he starts the patient on an acid reducing medication, adjusts the amount of anti-inflammatory over-the-counter medication the patient is currently taking. He also prescribes a new narcotic pain medication for the patient to help with the joint pain.

The PCP produces as encounter based document at the end of the visit and shares it with his patient. He wants to provide his patient with a meaningful recap of what they discussed during the visit. The encounter based document contains the medications that were changed, added and reviewed during this visit as well as instructions and procedures performed. However, due to the requirements of the document type specification it also contains other medications and problems, along with other types of information, such as immunizations, that were not addressed. The PCP would like to generate an Encounter Summary Section specific to the things that were pertinent to his interactions with the patient during the encounter.

##### X.4.2.3.2 Encounter Summary Section Process Flow

Patient Portal  
(Content Consumer)

Actor E

Actor D/

Actor E

PCP  
(Content Creator)

Actor B

Actor A /

Actor B

Share Content

Transaction-A [A]

Check for needed information

Generate Encounter Summary Section

Share CDA document

Figure X.4.2.3.2-1: Basic Process Flow in CDA-DSS Profile

Pre-conditions:

The PCP CDA encounter document must contain the information needed to satisfy the Encounter Summary Section rendering.

Main Flow:

The content creator provides the ability to check the CDA document for the information needed to create the Encounter Summary Section. At a minimal, the CDA document includes the pertinent encounter related content. This information will be used to populate the Encounter Summary Section. For example, the PCP would like to generate an Encounter Summary Section with medications that were changed, prescribed or discontinued during the encounter, as well as applicable procedures that were done and instructions that were provided. The document will need to contain the applicable medications, procedures and instructions information. This information is used to populate the Encounter Summary Section.

Post Conditions:

An Encounter Summary Section containing the relevant medication, procedure and instructions components is generated. The encounter document containing the Encounter Summary Section is shared with the patient.

#### X.4.2.4 Use Case #4: Active/Planned Medications Summary Section

This use case involves a Consulting Physician generating and viewing medication information in a referral document he has received.

##### X.4.2.4.1 Active/Planned Medications Summary Section Use Case Description

This use case involves the referral of a patient from their Primary Care Physician to a specialist (Consulting Provider). The patient, who is a diabetic, arrives at the primary care provider’s clinic for a yearly physical. During the physical exam, the PCP notes some signs of irregularities with the patient’s cardiac system. The PCP decides to refer the patient to a Cardiologist for further evaluation and treatment of the issue.

The PCP produces a referral document at the end of the visit and shares it with the specialist. This document contains the problems, physical exam, allergies, procedures, lab results and medications for the patient.

The specialist receives the document and notices the medication section is extremely long with a list of medications that the patient is currently taking, medications that have been prescribed but the patient has not started taking and medications that the patient is no longer taking. To further determine how to diagnose and treat the patient, the cardiologist would like to see all current and planned medications along with their related indications.

##### X.4.2.4.2 Active/Planned Medications Summary Section Process Flow

PCP  
(Content Creator)

Actor E

Actor D/

Actor E

Cardiologist  
(Content Consumer)

Actor B

Actor A /

Actor B

Share Content

Transaction-A [A]

Check for needed information

Generate Active/Planned Medication Summary Section

Render Active/Planned Medication Summary Section

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

Pre-conditions:

The PCP referral document must contain the information needed to satisfy the Active/Planned Medications Summary Section rendering.

Main Flow:

The content creator provides the ability to check the referral document for the information needed to create the Active/Planned Medications Summary Section. At a minimal, the referral document includes the pertinent medication related content. This information will be used to populate the Active/Planned Medications Summary Section. For example, the Specialist would like to generate an Active/Planned Medications Summary Section with medications that are active (patient is currently taking) and mediations that are planned (patient is to start taking at a future time), as well as applicable indications for each medication.

Post Conditions:

An Active/Planned Medications Summary Section is generated containing the relevant active and planned medications along with the applicable indications. The Active/Planned Medications Summary Section is rendered to be viewed by the Specialist.

#### X.4.2.5 Use Case #5: Document Summary Section

A provider is sending a CDA document and would like to communicate specific information to the receiving provider about the document or relevant information in the document. The provider creates the CDA document and include a Document Summary Section which contains the needed information.

##### X.4.2.5.1 Document Summary Section Use Case Description

This use case involves the transition of a patient from one care setting to another. The patient suffered a recent traumatic brain injury and is transferring from an acute rehabilitation care setting to a post-acute care setting. The transferring provider creates a CDA Transfer Summary Document. He would like the receiving provider to know the purpose of the document and portions or items in the document that the receiving provider should pay special attention to. The Transfer Summary document contains the problems, physical exam, allergies, procedures, lab results and medications for the patient. The transferring provider includes a Document Summary Section which contains information about the purpose of document. He also calls attention to the patient’s care team members and specific procedures and results in the document.

##### X.4.2.5.2 Document Summary Section Process Flow

Post-Acute Care Provider  
(Content Consumer)

Actor E

Actor D/

Actor E

Acute Care Provider  
(Content Creator)

Actor B

Actor A /

Actor B

Share Content

Transaction-A [A]

Create CDA document

Include Document Summary Section

Share CDA document

Figure X.4.2.5.2-1: Basic Process Flow in CDA-DSS Profile

Pre-conditions:

The transferring provider creates a CDA Transfer Summary document and include a Document Summary Section.

Main Flow:

The content creator provides the ability to create a CDA document which includes the Synopsis section. For example, the transferring provider generates a Transfer Summary document which contains pertinent procedures and results which he would like to call the receiver’s attention. He would also like to call the receiver’s attention to members of the patient’s care team and their applicable roles as well as their best means of contact. He includes this information in the Document Summary Section and adds it to the document. The document also includes the other section with the content he refers to.

Post Conditions:

A Transfer Summary document is generated containing the Document Summary Section and the relevant content. The Transfer summary document is shared with the receiving provider.

#### X.4.2.6 Use Case #6: Notes Section

A Consulting Provider is sending a CDA document and would like to communicate a specific note to the Primary Care Provider. The Consulting Provider creates the CDA document and includes a Notes Section.

##### X.4.2.6.1 Notes Section Use Case Description

This use case involves the consultation of a patient by their specialist (Consulting Provider) with plans for their Primary Care Provider (PCP) to resume care.

The patient, who has new onset atrial fibrillation, arrives at the specialist’s clinic for a follow-up consult visit. During the visit, the specialist discusses the recent diagnosis and plan of treatment with the patient. The specialist decides to return care of the patient back to the PCP.

At the end of the consultation period, the specialist creates a CDA Consultation document to share with the PCP. This document contains the problems, physical exam, allergies, procedures, lab results and medications for the patient. The specialist would like to include a consultation letter with the CDA consultation document. The specialist includes a Notes Section that contains the consultation letter.

##### X.4.2.6.2 Notes Section Process Flow

PCP  
(Content Consumer)

Actor E

Actor D/

Actor E

Consulting Provider  
(Content Creator)

Actor B

Actor A /

Actor B

Share Content

Transaction-A [A]

Create CDA document

Include Notes Section

Share CDA document

Figure X.4.2.6.2-1: Basic Process Flow in CDA-DSS Profile

Pre-conditions:

The consulting provider creates a CDA Consultation Note document and include a Notes Section.

Main Flow:

The content creator provides the ability to create a CDA document which includes the Notes Section. For example, the consulting provider generates a Consultation Note document which contains problems, physical exam, allergies, procedures, lab results and medications for the patient.

He would like to include a consultation letter. He includes this information in the Notes Section and adds it to the document.

Post Conditions:

A Consultation Note document is generated containing the Notes Section and other relevant content. The Consultation Note document is shared with the PCP.

#### X.4.2.7 Use Case #7: Care Team Summary Section

A patient is a being treated by two different Primary Care Providers at different time of the year (Snowbird). The patient is sending a CDA document to the provider that is about to take over his care. He would like to communicate his Care Team information so the provider would know who to contact in case information about his care is needed. The patient creates a CDA document and include a Care Team Summary Section.

##### X.4.2.7.1 Care Team Summary Section Use Case Description

Mr. Jonathan Allan is a 77 year old male ‘snowbird’. He lives in Michigan during the summer and lives in Florida the rest of the year. When he is in Michigan, his daughter Emily is his primary caregiver. When he’s in Florida, his son Eric is his primary caregiver. He has diabetes and has also undergone multiple open heart surgeries to correct irregular heartbeats and other ailments related to the heart. He is currently planning his return to Michigan. He makes an appointment with his Cardiologist in Michigan. He updates his care team information and includes it in his CDA document. He would like to share this information with his cardiologist in Michigan.

##### X.4.2.7.2 Care Team Summary Section Process Flow

Cardiologist  
(Content Consumer)

Actor E

Actor D/

Actor E

Patient   
(Content Creator)

Actor B

Actor A /

Actor B

Share Content

Transaction-A [A]

Create CDA document

Include Care Team Section

Share CDA document

Figure X.4.2.7.2-1: Basic Process Flow in CDA-DSS Profile

Pre-conditions:

The patient creates a CDA document and include a Care Team Summary Section.

Main Flow:

The content creator provides the ability to create a CDA document which includes the Care Team Summary Section. For example, the patient generates a CDA document which contains a list of his health concerns, goals, and medications he is currently taking.

He would like to include contact information about members of his most recent care team. He includes this information in the Care Team Summary Section and adds it to the document.

Post Conditions:

A CDA document is generated containing the Care Team Summary Section and other relevant content. The CDA document is shared with the cardiologist.

## X.5 CDA-DSS Security Considerations

See [ITI TF-2.x Appendix Z.8](http://ihe.net/uploadedFiles/Documents/ITI/IHE_ITI_Suppl_Appx-Z.pdf) “Mobile Security Considerations”

## X.6 CDA-DSS Cross Profile Considerations

The Content Creator and Content Consumer Actors are those used by all PCC Profiles. The options introduced by these actors are in addition to other PCC Profile options. For example, an implementation of the XDS-MS Profile might declare use of the Summary Section Option as well as Content Creator View Option. Similarly, an implementation might declare conformance to both the Summary Section Option as well as the Content Consumer View Option.

Volume 2 – Transactions

Add Section 3.Y

## 3.Y Summary Section Option

### 3.Y.1 Content Creator

A Content Creator that supports the supports the Summary Section Option SHALL provide the capability for a Content Consumer to render the section by producing documents that include the section.

### 3.Y.2 Content Consumer

The Content Consumer that supports the Summary Section Option SHALL be able to determine how to render the section.

<*Alternative 1*> Table 3.Y.2-1: Actor Roles

|  |  |
| --- | --- |
| **Actor:** | <Official actor name; list every actor in this transaction.> |
| **Role:** | <Very brief, one phrase, description of the role that this actor plays in this transaction.> |
| **Actor:** |  |
| **Role:** |  |
| **Actor:** |  |
| **Role:** |  |

*<The assignment and use of role names in transaction specifications has proved to be very effective/efficient in Radiology, especially when existing transactions are re-used by additional actors. Following is an alternative example of the Role section. Delete whichever form of the role section you choose not to use.>*

The roles in this transaction are defined in the following table and may be played by the actors shown here:

<*Alternative 2*>Table 3.Y.2-1 Actor Roles

|  |  |
| --- | --- |
| **Role:** | *<Role Name:><Only unique within this transaction. Typically one word. The Role Name is analogous to SCU or SCP in DICOM Services.>* |
| **Actor(s):** | The following actors may play the role of *<Role Name>*:  *<Actor Name>: <optionally, the situation where the actor would play this role if needed for clarity.>”* |
| **Role:** | *<e.g., Requestor:*  *Submits the relevant details and requests the creation of a new workitem.>* |
| **Actor(s):** | *<e.g., The following actors may play the role of Requestor:*  *Workitem Creator: when requesting workitems*  *Workitem Performer: when performing unscheduled workitems>* |
| **Role:** | *<e.g., Manager:*  *Creates and manages a Unified Procedure Step instance for the requested workitem.>* |
| **Actor(s):** | *<e.g., The following actors may play the role of Manager:*  *Workitem Manager: when receiving a new workitem for its worklist.>* |

Transaction text specifies behavior for each role. The behavior of specific actors may also be specified when it goes beyond that of the general role.

### 3.Y.3 Referenced Standards

* *<e.g., HL7 2.3.1 Chapters 2, 3>*
* *<e.g., DICOM 2008 PS 3.3: A.35.8 X-Ray Radiation Dose SR IOD>*
* *<e.g., applicable sub-sections in ITI TF-2x: Appendix Z on HL7 FHIR>*

### 3.Y.4 Interaction Diagram

<The interaction diagram shows the detailed standards-based message exchange that makes up the IHE transaction.>

Actor A

Message 1

Actor D

Message 2

#### 3.Y.4.1 <Message 1 Name>

<One or two sentence summary of what Message 1 accomplishes typically relating the message to the relevant standard. Avoid shall language in this upper level section. Do not duplicate the triggers, encoding, semantics, standards used, or expected actions. Those belong in the following sections.>

<Explicitly state if the multiplicity of an actor may be greater than one; i.e., if an actor (whether it is a client or server) can expect this message from a single source or multiple sources.>

##### 3.Y.4.1.1 Trigger Events

<Description of the real world events that cause the sender (Actor A) to send Message 1 (e.g., an operator or an automated function determines that a new workitem is needed).>

##### 3.Y.4.1.2 Message Semantics

<Detailed description of the meaning, structure and contents of the message, including any IHE specific clarifications of the message format, attributes, etc.>

<Start by describing the standard underlying the message and how the participating actors are mapped (e.g., “This message is a DICOM C-FIND Request. Actor A is the SCU. Actor D is the SCP.”).>

<Continue profiling the message by providing guidance or constraints on how the message parameters are populated, how the payload is encoded, how the message is structured and what the contents mean. These message semantics should both help the sender to construct the message and the receiver to interpret the message.>

##### 3.Y.4.1.3 Expected Actions

<Description of the actions expected to be taken as a result of sending or receiving this message.>

<Describe what the receiver is expected/required to do upon receiving this message. >

<Avoid re-iterating the transaction sequencing specified in the Profile Process Flows as expected actions internal to the transaction. Doing so prevents this transaction being re-used in other contexts.>

<Explicitly define any expected action based on the multiplicity of an actor(s), if applicable.>

#### 3.Y.4.2 <Message 2 Name>

<One or two sentence summary of what Message 2 accomplishes typically relating the message to the relevant standard. Avoid shall language in this upper level section. Do not duplicate the triggers, encoding, semantics, standards used, or expected actions. Those belong in the following sections.>

<Explicitly state if the multiplicity of an actor may be greater than one; i.e., if an actor (whether it is a client or server) can expect this message from a single source or multiple sources.>

<Repeat this section as necessary based on the number of messages in the interaction diagram.>

##### 3.Y.4.2.1 Trigger Events

<Description of the real world events that cause the sender (Actor A) to send Message 1(e.g., an operator or an automated function determines that a new workitem is needed).>

##### 3.Y.4.2.2 Message Semantics

<Detailed description of the meaning, structure and contents of the message, including any IHE specific clarifications of the message format, attributes, etc.>

<Start by describing the standard underlying the message and how the participating actors are mapped (e.g., “This message is a DICOM C-FIND Request. Actor A is the SCU. Actor D is the SCP.”).>

<Continue profiling the message by providing guidance or constraints on how the message parameters are populated, how the payload is encoded, how the message is structured and what the contents mean. These message semantics should both help the sender to construct the message and the receiver to interpret the message.>

##### 3.Y.4.2.3 Expected Actions

<Description of the actions expected to be taken as a result of sending or receiving this message.>

<Describe what the receiver is expected/required to do upon receiving this message. >

<Avoid re-iterating the transaction sequencing specified in the Profile Process Flows as expected actions internal to the transaction. Doing so prevents this transaction being re-used in other contexts.>

<Explicitly define any expected action based on the multiplicity of an actor(s), if applicable.>

### 3.Y.5 Protocol Requirements

<In this section, the selected protocol bindings of the transactions are explained in detail (like SOAP or HTTP bindings).For an example, see the QRPH DEX Profile or ITI TF-2b:3.34.5, 3.35.5. Indicate NA if not used.>

### 3.Y.6 Security Considerations

<Description of the transaction specific security consideration; such as use of security profiles.>

#### 3.Y.6.1 Security Audit Considerations

<This section should identify any specific ATNA security audit event that is associated with this transaction and requirements on the encoding of that audit event. >

##### 3.Y.6.(z) <Actor> Specific Security Considerations

<This section should specify any specific security considerations on an actor-by-actor basis.>

Appendices

<Detailed cross transaction relationships or mapping details are described in an appendix in Volume 2x. Volume 2 appendices may be informational or normative. Immediately after the title of a Volume 2 appendix, provide a very explicit statement defining whether this new appendix is informative or normative.

If there are no Volume 2 appendices, enter “Not applicable” and delete the Appendix A and Appendix B placeholder sections.>

# Appendix A – <Appendix Title>

Appendix A text.

## A.1 <Title>

Appendix A.1 text.

### A.1.1 <Title>

Appendix A.1.1 text.

# Appendix B – <Appendix Title>

Appendix B text.

## B.1 <Title>

Appendix B.1 text.

### B.1.1 <Title>

Appendix B.1.1 text.

# Volume 2 Namespace Additions

<For Public Comment, please explicitly identify all new OIDs, UIDs, URNs, etc., defined specifically for this profile. These items should be collected from the sections above, and listed here as additions to the applicable domain OID Registry. This section will be deleted prior to inclusion into the Technical Framework as Final Text, but should be present for publication of Public Comment and Trial Implementation.>

At Trial Implementation publication, the domain technical committee **must** ensure that all new OIDs, UIDs, URNs, etc., defined specifically for this profile have been recorded in their OID Registry. This section will be deleted prior to inclusion into the Technical Framework Volumes as Final Text but should be present for publication of Public Comment and Trial Implementation.>

The <domain name> registry of OIDs is located at <link to your OID registry(ies)

Additions to the <Domain Name> OID Registry are:

Volume 3 – Content Modules

<The current version of the supplement template only addresses HL7 v3 CDA Content Modules. All CDA Content Modules will go in Section 6 of Volume 3 of each domain’s Technical Framework document. In the future, this supplement template may have additional sections for DICOM Content Modules (section 7 of Volume 3) and other types of Content Modules (section 8, etc., of Volume 3).

<Please note that prior to the release of the new template set, some domains may have defined CDA Content Modules in Volume 2 (e.g., PCC); however, going forward CDA Content Modules will be defined in Volume 3.>

# 5 IHE Namespaces, Concept Domains and Vocabularies

Add to Section 5 IHE Namespaces, Concept Domains and Vocabularies

## 5.1 IHE Namespaces

<**For Public Comment publication**, please explicitly identify all **new** OIDs, UIDs, URNs, etc., defined specifically for this profile. These items should be collected from the sections within this supplement and listed here as additions to the applicable domain OID Registry. The tables within this section will be deleted prior to inclusion into the Technical Framework as Final Text, but should be present for publication for Public Comment.>

<**For Trial Implementation publication**, the domain technical committee **must** ensure that all new OIDs, UIDs, URNs, etc., defined specifically for this profile (and listed here for public comment publication have now been recorded in their OID Registry. The tables within this section will be deleted prior to inclusion into the Technical Framework Volumes as Final Text but should be present for publication for Trial Implementation.>

<Ensure the domain’s registry of OIDs is linked to from the following wiki page. It may be another wiki page, a document on the ftp site, etc.>

The <domain name> registry of OIDs is located at <http://wiki.ihe.net/index.php/OID_Registration#IHE_Domain_Namespaces>

Additions to the <Domain Name> OID Registry are:

| codeSystem | codeSystemName | Description |
| --- | --- | --- |
| <oid or uid> | <code system name> | <short description or pointer to more detailed description> |
| <oid or uid> | <code system name> | <short description or pointer to more detailed description> |
| <oid or uid> | <code system name> | <short description or pointer to more detailed description> |

## 5.2 IHE Concept Domains

<Concept Domains are named categories of things that are used when it isn’t possible to bind to a specific set of codes. There are a number of reasons you might not be able to define and bind to a specific set of codes, one of the most common being that the codes set needs to vary depending on locale or context.>

For a listing of the <Domain Acronym> Concept Domains see <enter location of the domains Concept Domains or NA if none>

| conceptDomain | conceptDomainName | Description |
| --- | --- | --- |
| <oid or uid> | <code system name> | <short description or pointer to more detailed description> |
| <oid or uid> | <code system name> | <short description or pointer to more detailed description> |
| <oid or uid> | <code system name> | <short description or pointer to more detailed description> |

## 5.3 IHE Format Codes and Vocabularies

### 5.3.1 IHE Format Codes

List in the table below any **new** format codes to be added to the IHE Format Codes wiki page at <http://wiki.ihe.net/index.php/IHE_Format_Codes>. For public comment, the additions must be listed in the table below. The domain technical committee must ensure any new codes are also added to the wiki page prior to publication for trial implementation.

| Profile | Format Code | Media Type | Template ID |
| --- | --- | --- | --- |
| <Profile name (profile acronym)> | <urn:ihe: > |  | <oids> |
|  |  |  |  |
|  |  |  |  |

### 5.3.2 IHEActCode Vocabulary

List in the table below, any **new** additions to the IHEActCode Vocabulary wiki page at <http://wiki.ihe.net/index.php/IHEActCode_Vocabulary>. For public comment, the additions must be listed in the table below. The domain technical committee must ensure any new codes are also added to the wiki page prior to publication for trial implementation.

|  |  |
| --- | --- |
| Code | Description |
| <Code name> | <short one sentence description or reference to longer description (not preferred)> |
| <Code name> | <short one sentence description or reference to longer description (not preferred)> |
| <Code name> | <short one sentence description or reference to longer description (not preferred)> |

### 5.3.3 IHERoleCode Vocabulary

List in the table below any **new** additions to the IHERoleCode Vocabulary wiki page at <http://wiki.ihe.net/index.php/IHERoleCode_Vocabulary>. For public comment, the additions must be listed in the table below. The domain technical committee must ensure any new codes are also added to the wiki page prior to publication for trial implementation.

| Code | Description |
| --- | --- |
| <name of role> | <Short, one sentence description of role or reference to more info.> |
| <name of role> | <Short, one sentence description of role or reference to more info.> |
| <name of role> | <Short, one sentence description of role or reference to more info.> |

# 6 Content Modules

<Authors’ notes: This section of the supplement template is only for HL7 v3 CDA Content Module definitions. Please delete the entire section 6.3.1 if the Content Module is based on DICOM or another standard.

Please note that the template for DICOM or other types of content modules (other than CDA) has not yet been defined, although DICOM modules will eventually go into Volume 3 Section 7; yet another type of content module will go into Volume 3 Section 8, etc.>

### 6.3.1 CDA Document Content Modules

<Authors’ instructions: The understanding of content module grouping, options, and bindings are critical to CDA content modules. It is strongly recommended that the author review the IHE Technical Frameworks General Introduction section 10.3 and the Patient Care Coordination (PCC) Technical Framework Volume 2 sections 3 and 4 (PCC TF-2:3 and 4) prior to continuing. A critical understanding of CDA definitions for cardinality, optionality, coded terminology values, and CDA content module structure, as well as IHE CDA formatting conventions is also necessary. It is strongly recommended that the author is also conversant with the IHE Technical Frameworks General Introduction Appendix E “Conventions”.>

<This CDA Content Module template is divided into four parts:

D – Document –“D” will be replaced with a sub-section number when added to the Technical Framework

H – Header - “H” will be replaced with a sub-section number when added to the Technical Framework

S – Section - “S” will be replaced with a sub-section number when added to the Technical Framework

E – Entry - “E” will be replaced with a sub-section number when added to the Technical Framework

It is expected that the author will **replicate** each of these four parts as necessary within a supplement.>

**All examples should be deleted after the example has been read and understood.>**

Add to section 6.3.1.D Document Content Modules

<Authors’ Note: Replicate section 6.3.1.D for every CDA Document defined in this profile. Number as 6.3.1.**D1**, 6.3.1.**D2**, etc.>

#### 6.3.1.D <Content Module Name (Acronym)> Document Content Module

##### 6.3.1.D.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:dom:name:year**

<where **dom** is the domain abbreviation; **name** is an identifying profile, transaction, etc. name; and **year** is the year the profile is expected to reach trial implementation. For example, urn:ihe:card:imaging:2011>

##### 6.3.1.D.2 Parent Template

<The following text is common, so it is left here for consistency. If it is not relevant, then change the text to the accurate information, but retain the formatting convention. Be sure to include **all** parent templates.>

<e.g., This document is a specialization of the IHE PCC Medical Document template (OID = 1.3.6.1.4.1.19376.1.5.3.1.1.1).>

<e.g., Note: The Medical Document includes requirements for various header elements; name, addr and telecom elements for identified persons and organizations; and basic participations record target, author, and legal authenticator.>

<e.g., This document is a specialization of the HL7 Procedure Note template (OID = 2.16.840.1.113883.10.20.18.1).>

<e.g., Note: This document is not a specialization of the HL7 Basic Diagnostic Imaging Report template due to conflicts with two Procedure Note requirements (format of serviceEvent/effectiveTime, and title on DICOM Catalogue section). When and if these are resolved, an instance may also comply to the Diagnostic Imaging Report.>

##### 6.3.1.D.3 Referenced Standards

<Identify **all** standards referenced by **this** content module.>

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

Table 6.3.1.D.3-1: <Document Name> - Referenced Standards

| Abbreviation | Title | URL |
| --- | --- | --- |
| <abbreviated name of standard> | <full name of standard> | <link to standard> |
| <abbreviated name of standard> | <full name of standard> | <link to standard> |
| <e.g., CDA-PN> | <e.g., HL7 Implementation Guide for CDA Release 2: Procedure Note (Universal Realm) (DSTU)> | <e.g., http://www.hl7.org/documentcenter/public/standards/dstu/CDAR2\_IG\_PROCNOTE\_DSTU\_R1\_2010JUL.zip> |

##### 6.3.1.D.4 Data Element Requirement Mappings to CDA

This section identifies the mapping of data between referenced standards into the CDA implementation guide.

<Any required data mappings should be listed in this section (mark NA if not needed). Delete SAMPLE table before publishing.>

*<To complete Table 6.3.1.D.4-1, the author should add the referenced standards abbreviations in the first row/title bar. Add or delete columns and sub-rows as necessary. If this table is more than 8 to 10 rows long, consider putting this table into an appendix of this supplement. A brief sample follows.>*

SAMPLE

| ACC Key Data Element (KDECI) | CDA-DIR |
| --- | --- |
|  | DICOM Object Catalog (5) |
| Administrative  Facility (5)  Data Source (1)  Priority (1)  Accreditation (2)  Insurance (1) | CDA Header  General (10)  Document (19)  Participants (20)  Order (1)  Service Event (12)  Encounter (10) |
| Study Referral Data (2) | Request |
| History and Risk Factors  Vital Signs (4)  Labs (2)  Problems (14)  Chest Pain (5)  Family History (1)  Tobacco Use (1)  Risk Estimates (6) | History |

*>*

Table 6.3.1.D.4-1: < Document Name Acronym> - Data Element Requirement Mappings to CDA

| Clinical Data Element <source> | < this document acronym> |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

<**Very important note:** From this point forward, the author may select one of two formats to represent the same data. The first format is a tabular format as was implemented in the Cardiology CIRC profile. The advantages to this format include that large amounts of data may be represented more concisely and that it is sometimes visually easier to determine if any information is missing. The second format is more similar to the current Consolidated CDA (C-CDA format). This format may be more verbose but may also be more recognizable to implementers familiar with other HL7 CDA Implementation Guides and may be easier for implementers to design and test with discrete conformance assertions.

The format that you select must be consistent through this supplement (do not mix and match formats). The format changes are identified by ###Begin Tabular format ###End CDA Tabular format and ###Begin Discrete Conformance format ###End Discrete Conformance format. Delete all references to the format which was not selected between the hash marks. Also, a domain may decide on a single format for all new supplements within that domain.>

##### 6.3.1.D.5 <Content Module Name (Acronym, if applicable)> Document Content Module Specification

This section specifies the header, section, and entry content modules which comprise the <Content Module Name (Acronym)> Document Content Module, using the Template ID as the key identifier.

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

<Authors’ note: A critical understanding of CDA definitions for cardinality, optionality, coded terminology values, and CDA content module structure, as well as IHE CDA formatting conventions is necessary. It is strongly recommended that the author is also conversant with the IHE Technical Frameworks General Introduction Appendix E “Conventions”. >

###Begin Tabular format - Document

Table 6.3.1.D.5-1 <Content Module Name (Acronym)> Document Content Module Specification

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Template Name | | <Template Name (Acronym, if applicable)> | | | |
| Template ID | | <oid/uid> | | | |
| Parent Template | | <Parent Template Name oid/uid [Domain Reference]>  <Parent Template Name oid/uid [Domain Reference]> <delete 2nd/additional parent template if not applicable>  <Enter NA if none> | | | |
| General Description | | <short textual description> | | | |
| Document Code | | <MAY or SHALL> be < code/oid/uid, Code System, “Value Set name”> | | | |
| Opt and Card | Condition | Header Element or Section Name | Template ID | Specification Document | Vocabulary Constraint |
| Header Elements | | | | | |
| x [?..?] |  | <Header Element name> | <oid> | <reference to section of TF or supplement document for details> | <reference to section of TF or supplement document for explanation, if applicable> |
| <e.g., R [0..1] |  | Order | 1.3.6.1.4.1.19376.1.4.1.3.2 | CARD TF-3 6.3.2.H> |  |
| <e.g., M [1..1] |  | Patient Demographics | 1.3.6.1.4.1.19376.1.4.1.3.3 | CARD TF-3 6.3.2.H | CARD TF-3 6.3.1.D.5.1> |
| Sections | | | | | |
| x [?..?] |  | <Section name> | <oid> | <reference to section of TF or supplement document for details> | <reference to section of TF or supplement document for explanation, if applicable> |
| <e.g., M [1..1] |  | Medications | 1.3.6.1.4.1.19376.1.5.3.1.3.19 | PCC TF-2 | CARD TF-3 6.3.1.D.5.2> |
| <e.g., R [1..1] |  | Coded Social History | 1.3.6.1.4.1.19376.1.5.3.1.3.16.1 | CARD TF-3 6.3.3.S | CARD TF-3 6.3.1.D.5.3> |
| <e.g., O [0..1] |  | Physical Examination | 2.16.840.1.113883.10.20.2.10 | CDA-PN> |  |
| <e.g., C [1..1] | CARD TF-3 6.3.1.D.5.4 | DICOM Object Catalog | 1.3.6.1.4.1.19376.1.4.1.2.15 | CDA-PN> |  |

<For each (1:1 correspondence) Vocabulary Constraint or Condition listed in the table above, create an additional section/reference below. Add the Header Element or Section Name and then select either “Vocabulary Constraint” or “Condition” and delete the other word.>

<Note that every Conditional element MUST have an explanatory paragraph referenced below.>

<It is required to use SHALL, SHOULD, or MAY in each definition as defined in Appendix E of the Technical Frameworks General Introduction.>

###### 6.3.1.D.5.1 <Header Element or Section Name> <Vocabulary Constraint or Condition>

<add vocabulary constraint or condition definition>

<remove example below prior to public comment:>

<e.g., The value for serviceEvent / code SHOULD be drawn from value set 1.3.6.1.4.1.19376.1.4.1.5.2 Cardiac Imaging Procedures.

OR

The value for serviceEvent/code SHOULD be drawn from the value set bound to the concept domain UV\_CardiacImagingProcedures.>

###### 6.3.1.D.5.2 <Header Element or Section Name> <Vocabulary Constraint or Condition>

<add vocabulary constraint or condition definition>

<remove example below prior to public comment:>

<e.g., Within the Medications section the Content Creator SHALL be able to create a Medications entry (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2]) for each of the cardiac relevant medications identified in Value Set 1.3.6.1.4.1.19376.1.4.1.5.14 Cardiac Drug Classes, encoding the value in substanceAdministration/consumable/ManufacturedProduct/Material/code.

OR

Within the Medications section the Content Creator SHALL be able to create a Medications entry (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2]) for each of the cardiac relevant medications identified in the value set bound to the concept domain UV\_CardiacRelevantMedications, encoding the value in substanceAdministration/consumable/ManufacturedProduct/Material/code.

>

###### 6.3.1.D.5.3 <Header Element or Section Name> <Vocabulary Constraint or Condition>

<add vocabulary constraint or condition definition>

<remove example below prior to public comment:>

<e.g., Within the Allergies and Other Adverse Reactions section the Content Creator SHALL be able to create an Allergies and Intolerances Concern Entry (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.5.3 [PCC TF-2]) for each of the cardiac imaging agent classes identified in Value Set 1.3.6.1.4.1.19376.1.4.1.5.10 Contrast Agents Classes for Adverse Reactions, encoding the value in observation/participant/participantRole/playingEntity/code.

OR

Within the Allergies and Other Adverse Reactions section the Content Creator SHALL be able to create an Allergies and Intolerances Concern Entry (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.5.3 [PCC TF-2]) for each of the cardiac imaging agent classes identified in value set bound to the concept domain UV ContrastAgentsClasses, encoding the value in observation/participant/participantRole/playingEntity/code.

>

###### 6.3.1.D.5.4 <Header Element or Section Name> <Vocabulary Constraint or Condition>

<add vocabulary constraint or condition definition>

<remove example below prior to public comment:>

<e.g., A DICOM Object Catalog Section SHALL be present if other document sections contain references to DICOM SOP Instances (images, structured report measurements, or other information objects), and MAY be present otherwise.>

**###End Tabular Format - Document**

**###Begin Discrete Conformance Format - Document**

*<Delete the example information contained in the material below (from Cardiology CRC)>*

<e.g., The complete set of body constraints, including those from C-CDA section/entry definitions are:

1. SHALL contain exactly one [1..1] **component** (CONF:9588).
   1. A Cath Report Content **SHALL** have a structuredBody (CONF:9589-CRC).
      1. A Cath Report Content **SHALL** conform to CDA Level 3 (structuredBody containing sections that contain a narrative block and coded entries). In this template (templateId 2.16.840.1.113883.10.20.22.1.6), coded entries are optional. (CONF:9590-CRC).
   2. The component/structuredBody SHALL conform to the section constraints below (CONF:9595-CRC).
      1. Each section SHALL have a title and the title SHALL not be empty (CONF:9937).>

<The following table shows relationships among the templates in the body of a Cath Report Content document.>

Table 6.3.1.D.5-1 <Content Module Name (Acronym)> Document Content Module Specification

| Template Title | Opt and Card | Condition | Template Type | templateId | Vocabulary  Constraints |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Delete this row and the example information in the rows below. | | | | | |
| <e.g., Cath Report Content | R[1..1] |  | document | 1.3.6.1.4.1.19376.1.4.1.1.2 | 6.3.1.D.5.1 |
| Document Summary-Cardiac Section | O[0..1] |  | Section | 1.3.6.1.4.1.19376.1.4.1.2.16 |  |
| Medical History - Cardiac Section | R[1..1] |  | Section | 1.3.6.1.4.1.19376.1.4.1.2.17 |  |
| Procedure Activity Observation | O[0..\*] |  | Entry | 2.16.840.1.113883.10.20.22.4.13 |  |
| Procedure Activity Procedure | O[0..\*] |  | Entry | 2.16.840.1.113883.10.20.22.4.14 |  |
| Problem Observation - Cardiac | O[0..\*] |  | Entry | 2.16.840.1.113883.10.20.22.4.4 |  |
| Age Observation | O[0..1] |  | Entry | 2.16.840.1.113883.10.20.22.4.31 |  |
| Health Status Observation | O[0..1] | 6.3.1.D.5.2 | Entry | 2.16.840.1.113883.10.20.22.4.5 |  |
| Problem Status | O[0..1] |  | Entry | 2.16.840.1.113883.10.20.22.4.6 |  |
| Severity Observation | O[0..1] |  | Entry | 2.16.840.1.113883.10.20.22.4.8 |  |
| Allergies Section | R[1..1] |  | Section | 2.16.840.1.113883.10.20.22.2.6 |  |
| Allergy Problem Act | O[0..\*] |  | Entry | 2.16.840.1.113883.10.20.22.4.30 |  |
| Allergy Observation | R[1..\*] |  | Entry | 2.16.840.1.113883.10.20.22.4.7 |  |
| Allergy Status Observation | O[0..1] |  | Entry | 2.16.840.1.113883.10.20.22.4.28 |  |
| Reaction Observation | O[0..1] |  | Entry | 2.16.840.1.113883.10.20.22.4.9 |  |
| Severity Observation | O[0..1] |  | Entry | 2.16.840.1.113883.10.20.22.4.8 |  |
| Family History – Cardiac Section | O[0..1] |  | Section | 1.3.6.1.4.1.19376.1.4.1.2.18 |  |
| Problem Observation - Cardiac | O[0..\*] |  | Entry | 2.16.840.1.113883.10.20.22.4.4 |  |
| Social History Section | O[0..1] |  | Section | 2.16.840.1.113883.10.20.22.2.17 |  |
| Physical Exam Section | R[1..1] |  | Section | 2.16.840.1.113883.10.20.2.10 |  |
| Vital Signs | R[1..1] |  | Section | 2.16.840.1.113883.10.20.22.2.4.1 |  |
| Vital Signs Organizer | R[1..\*] |  | Entry | 2.16.840.1.113883.10.20.22.4.26 |  |
| Vital Sign Observation | R[2..\*] |  | Entry | 2.16.840.1.113883.10.20.22.4.27> |  |

<For each (1:1 correspondence) Vocabulary Constraint or Condition listed in the table above, create an additional section/reference below. Add the Header Element or Section Name and then select either “Vocabulary Constraint” or “Condition” and delete the other word.>

<Note that every Conditional element MUST have an explanatory paragraph referenced below.>

<It is required to use SHALL, SHOULD, or MAY in each definition as defined in Appendix E of the Technical Frameworks General Introduction.>

###### 6.3.1.D.5.5 <Template Title name> <Vocabulary Constraint or Condition>

<add vocabulary constraint or condition definition>

<remove example below prior to public comment:>

<e.g., The value for serviceEvent / code SHOULD be drawn from value set 1.3.6.1.4.1.19376.1.4.1.5.2 Cardiac Imaging Procedures.

OR

The value for serviceEvent / code SHOULD be drawn from the value set bound to the concept domain UV\_CardiacImagingProcedures

>

###### 6.3.1.D.5.6 <Template Title name> <Vocabulary Constraint or Condition>

<add vocabulary constraint or condition definition>

<remove example below prior to public comment:>

<e.g., Within the Medications section the Content Creator SHALL be able to create a Medications entry (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2]) for each of the cardiac relevant medications identified in Value Set 1.3.6.1.4.1.19376.1.4.1.5.14 Cardiac Drug Classes, encoding the value in substanceAdministration/consumable/ManufacturedProduct/Material/code.

OR

Within the Medications section the Content Creator SHALL be able to create a Medications entry (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.7 [PCC TF-2]) for each of the cardiac relevant medications identified in the value set bound to the concept domain UV\_CardiagDrugClasses, encoding the value in substanceAdministration/consumable/ManufacturedProduct/Material/code.

>

**###End Discrete Conformance Format - Document**

##### 6.3.1.D.6 <Document and Acronym Name> Conformance and Example

<This section is the same, independent of whether the tabular or discrete conformance formats were chosen.>

<Describe the conformance of this document in terms of inheritance from other templates. Use the OIDs of those templates for clarity. A complete example of this document MUST be placed on the IHE ftp server as part of the Public Comment process of a Content Module supplement at ftp://ftp.ihe.net/TF\_Implementation\_Material/. The file naming convention for these files should be <Domain Acronym>\_<Profile Acronym>\_CDA-sample\_<version number>.xml where version number is the version number of the profile>.

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

A CDA Document may conform to more than one template. This content module inherits from the *<template name(s) and template ID(s)>* <e.g., CDA-PN, 2.16.840.1.113883.10.20.18.1, and the PCC TF Medical Document, 1.3.6.1.4.1.19376.1.5.3.1.1.1, content modules> and so must conform to the requirements of those templates as well this document specification, *<templateName and templateID>* <e.g., Cardiac Imaging Report template, 1.3.6.1.4.1.19376.1.4.1.1.1>.

A complete example of the <Content Module Name and Acronym> Document Content Module is available on the IHE ftp server at: <indicate location here>.

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

Add to section 6.3.2 Header Content Modules

### 6.3.2 CDA Header Content Modules

#### 6.3.2.H <Header Element Module Name> Header Content Module

<Authors’ Note: Replicate section 6.3.2.H for each Header Content Module defined in this profile. Number as 6.3.2.H**1**, 6.3.2.H**2**, etc.>

**###Begin Tabular Format - Header**

<Either the Parent Template OR the Header Element may constrain this Header Element, not both. One should be “N/A”.>

<The values in the column “Participations and Act Relationships” must come from the defined terms in the CDA schema. See the IHE Technical Frameworks General Introduction, Appendix E: CDA Conventions.>

Table 6.3.2.H-1 <Content Module Name (Acronym)> Header

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Template Name | | <Template Name> | | | | |
| Template ID | | <oid> | | | | |
| Parent Template | | <Name and oid of parent template or NA> | | | | |
| Header Element | | <CDA Header Elements participant or componentOf or NA>  e.g., componentOf / encompassingEncounter | | | | |
| General Description | | <short textual description. Short paragraph at most.> | | | | |
| Opt and Card | Participation/ Act Relationship | Description | Template | Specification Document | Vocabulary Con-straint |
| x [?..?] | <select from defined part /act relationship terms; App E> | <Header Content description name> | <oid> | <document reference, if applicable> | <Vocab constraint, if applicable> |
|  |  |  |  |  |  |
| <e.g., R [1..1] | RESP | Responsible Party |  | CARD TF-3: 6.3.2.H.1> |  |
| <e.g., R [1..1] | LOC | Health Care Facility |  | CARD TF-3: 6.3.2.H.2> |  |
| <e.g., O [0..1] | REF | Referring Provider |  | CARD TF-3: 6.3.2.H.3> |  |
| <e.g., C [0..1] | ATND | Physician of Record | 2.16.840.1.113883.10.20.6.2.2 | CDA-DIR | CARD TF-3: 6.3.2.H.4> |

*<For each Vocabulary Constraint or Specification Document listed in the table above, create an additional section/reference below. Add the Description Name and then select either “Vocabulary Constraint” or “Spec Document” and delete the other word.>*

*<It is required to use SHALL, SHOULD, or MAY in each definition as defined in Appendix E of the Technical Frameworks General Introduction.>*

*<Also note that the Specification Document link can be a link to an outside document/reference. Do not replicate (cut and paste) sections of other documents into this document since they could become out of sync.>*

##### 6.3.2.H.1 <Description Name> <e.g., Responsible Party> <Specification Document *or* Vocabulary Constraint>

<Describe constraints or other info. This specification may include more information on conditions or cardinality, additions elements, data mappings, or data types, or other information.>

<Delete the example below prior to publishing for Public Comment.>

<e.g., The responsible party element represents only the party responsible for the encounter, not necessarily the entire episode of care.>

<e.g., The responsibleParty element MAY be present. If present, responsibleParty/ assignedEntity SHALL have at least one assignedPerson or representedOrganization element present.>

<e.g., Note: This is identical to CDA-DIR CONF-DIR-67>

<e.g., responsibleParty assignedEntity id SHALL be present with the responsible physician’s identifier.>

<e.g., assignedEntity code SHOULD be present with the responsible physician’s specialty.>

<e.g., assignedEntity MAY include an accreditation element from the **urn:ihe:card** namespace to provide physician accreditation status.>

<e.g., The accreditation element SHALL use the character string (ST) data type.

The accreditation element SHALL appear after the defined elements of the Role class, and before any scoper or player entity elements.>

<e.g., assignedEntity assignedPerson name SHALL be present with the responsible physician’s name.>

##### 6.3.2.H.2 <Description Name> <Specification Document OR Vocabulary Constraint>

##### 6.3.2.H.3 <Description Name> <Specification Document OR Vocabulary Constraint>

**###End Tabular Format – Header**

**###Begin Discrete Conformance Format – Header**

The header for the <*Document Name*> document shall support the following header constraints as noted in this section. Note that this content profile is realm agnostic. These header constraints are based on the C-CDA header constraints but all references to US Realm specific types have been removed.

<An example is provided to demonstrate the desired consistent use and format. Delete this example prior to publication for Public Comment. The statement must be numbered, begin with SHALL/SHOULD/MAY, identify the cardinality using [n..n], the name of the element, and a subitem which describes the value or source of the information.>

<e.g.,

1. SHALL contain exactly one [1..1] **typeId** (CONF:5361).
   1. This typeId SHALL contain exactly one [1..1] **@root**="2.16.840.1.113883.1.3" (CONF:5250).
   2. This typeId SHALL contain exactly one [1..1] **@extension**="POCD\_HD000040" (CONF:5251).
2. SHALL contain exactly one [1..1] **templateId** (CONF:5252) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.4.1.1.2" for the Cath Report Content document template (CONF:CRC-xxx).
3. SHALL contain exactly one [1..1] **id** (CONF:5363).
   1. This id **SHALL** be a globally unique identifier for the document (CONF:9991).
4. SHALL contain exactly one or two [1..2] **code** (CONF:5253-CRC).
   1. SHALL be selected from ValueSet ProcedureNoteDocumentTypeCodes 2.16.840.1.113883.11.20.6.1 DYNAMIC (CONF:8497). Either or both of the following codes should be included:

|  |  |  |  |
| --- | --- | --- | --- |
| Value Set: ProcedureNoteDocumentTypeCodes 2.16.840.1.113883.11.20.6.1 DYNAMIC  Code System: LOINC 2.16.840.1.113883.6.1 | | | |
| LOINC Code | Type of Service ‘Component’ | Setting ‘System’ | Specialty/Training/Professional Level ‘Method\_Type’ |
| 18745-0 | Study report | Heart | Cardiac catheterization |
| 34896-1 | Interventional procedure note | {Setting} | Cardiology |

1. SHALL contain exactly one [1..1] **title** (CONF:5254).
   1. Can either be a locally defined name or the display name corresponding to clinicalDocument/code (CONF:5255).>

**###End Discrete Conformance Format – Header**

### 6.3.3 CDA Section Content Modules

Add to section 6.3.3.10 Section Content Modules

< Authors’ Note: Replicate section 6.3.3.10.S for each Section Content Module defined in this profile. Number as 6.3.3.10.S**1**, 6.3.3.10.S**2**, etc.>

<Authors’ notes: Section naming instructions: If a section is a specialization of an existing section, begin the name with the original section name. For example, if Cardiology is creating a specialization of the “Medical History Section”, the new section should be named “Medical History Section – Cardiac” and not “Cardiac Medical History Section”.>

**###Begin Tabular Format - Section**

<Delete examples in rows of table below prior to Public Comment.>

#### 6.3.3.10.S <Section Module Name> - Section Content Module

Table 6.3.3.10.S-1 <Section Module Name> Section

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Template Name | | <exact same Section Module name listed above> | | | |
| Template ID | | <oid> | | | |
| Parent Template | | <Parent Template Name oid/uid [Domain - Reference] or NA> | | | |
| General Description | | <brief textual description, one paragraph> | | | |
| Section Code | | <Code, Code Scheme, “Section Code Name”> | | | |
| Author | | <If inherited from encompassing content module use “current recordTarget”, unless otherwise specified. Role and entity must be specified if not inherited. > | | | |
| Informant | | <If inherited from encompassing content module use “current recordTarget”, unless otherwise specified.> | | | |
| Subject | | <If inherited from encompassing content module use “current recordTarget”, unless otherwise specified.> | | | |
| Opt and Card | Condition | Data Element or Section Name | Template ID | Specification Document | Vocabulary  Constraint |
| Subsections | | | | | |
| x [?..?] | <ref or link to cond section below, if applicable> | <name of subsection> | <oid> | <reference or link to specification document location, if applicable> | <reference or link to vocab constraint, if applicable> |
| <e.g., O [0..1] |  | Active Problems | 1.3.6.1.4.1.19376.1.5.3.1.3.6 | PCC TF-3> |  |
| <e.g., O [0..1] |  | History of Present Illness | 1.3.6.1.4.1.19376.1.5.3.1.3.4 | PCC TF-3> |  |
| <e.g., O [0..1] |  | History of Past Illness | 2.16.840.1.113883.10.20.2.9 | CDA-PN> |  |
| Entries | | | | | |
| x [?..?] | <ref or link to cond section below, if applicable> | <name of entry> | <oid> | <reference or link to specification document location, if applicable> | <reference or link to vocab constraint, if applicable> |
| <e.g., C [1..\*] | CARD TF-3 6.3.3.x.S.1 | Problem Concern Entry | 1.3.6.1.4.1.19376.1.5.3.1.4.5.2 | PCC TF-3> |  |
| <e.g., C [1..1] |  | Diabetes Problem Entry | 1.3.6.1.4.1.19376.1.4.1.4.1 | CARD TF-3 6.3.3.1> |  |
| <e.g., C [1..1] |  | Angina Problem Entry | 1.3.6.1.4.1.19376.1.4.1.4.2 | CARD TF-3 6.3.3.1> |  |
| <e.g., C [1..\*] | CARD TF-3 6.3.3.x.S.1 | Simple Observation | 1.3.6.1.4.1.19376.1.5.3.1.4.13 | PCC TF-3 | CARD TF-3 6.3.3.x.S.2> |

##### 6.3.3.10.S.1 <Data Element or Section Name> <Condition, Specification Document, or Vocabulary Constraint>

<Describe constraints; refer to other Specification Document, condition, or other info. This specification may include more information on conditions or cardinality, additions elements, data mappings, or data types, or other information.>

<Delete the example below prior to publishing for Public Comment.>

<e.g., The Medical History Section SHALL contain at least one Problem Concern Entry or at least one Simple Observation.

Note: Problems MAY be recorded directly in the Medical History Section, or in one or more subsections such as Active Problems, History of Present Illness, or History of Past Illness.>

##### 6.3.3.10.S.2 <Data Element or Section Name> <Condition, Specification Document, or Vocabulary Constraint>

<Describe constraints, refer to other Specification Document, condition, or other info. This specification may include more information on conditions or cardinality, additions elements, data mappings, or data types, or other information.>

<Delete the example below prior to publishing for Public Comment.>

<e.g., A Content Creator SHALL be able to include a Problem Concern Entry for each of the conditions identified in Value Set [1.3.6.1.4.1.19376.1.4.1.5.4 Cardiac Problems/Concerns](#_1.3.6.1.4.1.19376.1.4.1.5.4__Cardia), encoding the value in act/entryRelationship/observation/code.

A Problem Concern Entry for {73211009, SNOMED CT, diabetes} SHALL use the specialized Diabetes Problem Entry (OID = 1.3.6.1.4.1.19376.1.4.1.4.1).

A Problem Concern Entry for {194828000, SNOMED CT, angina} SHALL use the specialized Angina Problem Entry (OID = 1.3.6.1.4.1.19376.1.4.1.4.2).

OR

A Content Creator SHALL be able to include a Problem Concern Entry for each of the conditions identified in the Concept Domain UV\_CardiacProblems (See section X.X for the description/list of concepts in this domain), encoding the value in act/entryRelationship/observation/code.

A Problem Concern Entry for “diabetes” SHALL use the specialized Diabetes Problem Entry (OID = 1.3.6.1.4.1.19376.1.4.1.4.1).

A Problem Concern Entry for “angina” SHALL use the specialized Angina Problem Entry (OID = 1.3.6.1.4.1.19376.1.4.1.4.2).

>

##### 6.3.3.10.S.3 <Data Element or Section Name> <Condition, Specification Document, or Vocabulary Constraint>

**###End Tabular Format – Section**

**###Begin Discrete Conformance Format – Section**

<An example is provided to demonstrate the desired consistent use and format. Delete this example prior to publication for Public Comment. The statements must be numbered, begin with SHALL/SHOULD/MAY identify the cardinality using [n..n], the name of the element, and a subitem which described the value or source of the information.>

<e.g.,

#### 6.3.3.10.S Medical History - Cardiac Section 11329-0

[section: templateId 1.3.6.1.4.1.19376.1.4.1.2.17(open)]

[section: templateId 2.16.840.1.113883.10.20.22.2.39(open)]

The Medical History section describes all aspects of the medical history of the patient even if not pertinent to the current procedure, and may include chief complaint, past medical history, social history, family history, surgical or procedure history, medication history, and other history information. The history may be limited to information pertinent to the current procedure or may be more comprehensive. The history may be reported as a collection of random clinical statements or it may be reported categorically. Entries for History of Past Illness and History of Present Illness have been consolidated into this section. Social and Family History are discussed in their own sections. For this Cath Report Content profile, this section may also contain history about specific relevant problems as problem observations.

In the event that the patient was transferred from another facility where there was a problem indication that the patient was determined to need a cath procedure, this will be noted as a problem observation in this medical history section as text in the narrative for now until there is a code representing this.

1. SHALL contain exactly two [2..2] templateId (CONF:8160) such that it
   1. SHALL contain exactly one [1..1] @root="1.3.6.1.4.1.19376.1.4.1.2.17" (CONF:10403-CRC).
   2. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.39" (CONF:10403).
2. SHALL contain exactly one [1..1] code/@code="11329-0" Medical (General) History (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:8161).
3. SHALL contain exactly one [1..1] title (CONF:8162).
4. SHALL contain exactly one [1..1] text (CONF:8163).
5. MAY contain zero or more [0..\*] entry (CONF:CRC-xxx) such that it
   1. SHALL contain exactly one [1..1] Problem Observation - Cardiac (1.3.6.1.4.1.19376.1.4.1.4.9) (CONF:CRC-xxx).
6. MAY contain zero or more [0..\*] **entry** (CONF:CRC-xxx) such that it
   1. SHALL contain exactly one [1..1] **Procedure Activity Observation** (2.16.840.1.113883.10.20.22.4.13) (CONF:CRC-xxx).
7. MAY contain zero or more [0..\*] entry (CONF:CRC-xxx) such that it
   1. SHALL contain exactly one [1..1] Procedure Activity Procedure (2.16.840.1.113883.10.20.22.4.14) (CONF:CRC-xxx).

<section>

<templateId root="1.3.6.1.4.1.19376.1.4.1.2.17"/>

<templateId root="2.16.840.1.113883.10.20.22.2.39"/>

<code code="11329-0" codeSystem="2.16.840.1.113883.6.1"

codeSystemName="LOINC"

displayName="MEDICAL (GENERAL) HISTORY"/>

<title>MEDICAL (GENERAL) HISTORY</title>

<text>

<list listType="ordered">

<item>Patient has had a recent issue with chest pain that does not seem to be related to any particular cause.</item>

<item>Previous concerns of heart disease were actually related to other causes.</item>

<item>Patient had recent weight gain due to sedentary lifestyle and

new job.</item>

</list>

</text>

<entry>

<observation classCode=”OBS” moodCode=”EVN”>

<templateId root=”1.3.6.1.4.1.19376.1.4.1.9”/>

<id root=”xyz”/>

…

</observation>

</entry>

</entry>

<observation classCode="PROC" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.14"/>

<!-- Procedure Activity Procedure template -->

...

</observation>

</entry>

</entry>

<observation classCode="OBS" moodCode="EVN">

<templateId root="2.16.840.1.113883.10.20.22.4.13"/>

<!-- Procedure Activity Observation template -->

...

</observation>

</entry>

</section>

Figure Example: Example Section example>

**###End Discrete Conformance Format - Section**

### 6.3.4 CDA Entry Content Modules

Add to section 6.3.4.E Entry Content Modules

#### 6.3.4.E <Entry Content Module Name> Entry Content Module

<Authors’ Note: Replicate section 6.3.4.E for each Entry Content Module defined in this profile. Number as 6.3.4.E**1**, 6.3.4.E**2**, etc.>

<If this entry has subsidiary/child entries, these entries are referenced in the table below. Create one row for each subsidiary/child entry.>

**### Begin Tabular Format - Entry**

Table 6.3.4.E-1 <Entry Module Name> Entry

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Template Name | | | | <Template name> | | | | | | |
| Template ID | | | | <oid> | | | | | | |
| Parent Template | | | | <Parent Template Name oid/uid [Domain - Reference]> or NA | | | | | | |
| General Description | | | | <brief textual description, one paragraph> | | | | | | |
| Class/Mood | | Code | | | | Data Type | Value | | | |
| <use one of defined Class/Mood see General Intro App E> | | <Code, code system, code meaning e.g., 18118-0, LOINC, “LV Wall Motion Segmental Findings”> | | | | <Applies only if the Class/ Mood is OBS/EVN. Enumerated in HL7 V3 Data Types R1.> | <If the Class/Mood is OBS/EVN, then this Value field is the constraint on Observation Value. Otherwise, this field should be “N/A”.> | | | |
| Opt and Card | entryRelationship | | Description | | Template ID | | | Specification Document | Vocabulary Constraint |
| <e.g., x [?..?]> |  | | Simple Observation | | oid | | | reference to document e.g., PCC-TF-3 | <reference/link to definition of constraint, often in next paragraph/ subsection e.g., CARD TF-3 6.3.3.4.9.10> |
| <e.g., C [1..\*] | COMP | | Simple Observation | | 1.3.6.1.4.1.19376.1.5.3.1.4.13 | | | PCC TF-2 | CARD TF-3 6.3.4.E.1 (Wall morphology)> |
| <e.g., O [0..1] | COMP | | Simple Observation | | 1.3.6.1.4.1.19376.1.5.3.1.4.13 | | | PCC TF-2 | CARD TF-3 6.3.4.E.2 (Viability)> |
| <e.g., O [0..1] | COMP | | observationMedia Entry | | 1.3.6.1.4.1.19376.1.4.1.4.7 | | | CARD TF-3 6.3.1.6> |  |

##### 6.3.4.E.1 Simple Observation (wall motion) Vocabulary Constraints

<Describe constraints, refer to other Specification Document, condition, or other info. This specification may include more information on conditions or cardinality, additions elements, data mappings, or data types, or other information.>

<Can be in a tabular format or textual description.>

<Delete the example below prior to publishing for Public Comment.>

<e.g., The conditional entries specified in this table SHALL be present based on the exam type as specified in the CDA Header in the documentationOf / serviceEvent / code element.>

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Opt and Card | Condition | observation/code | Data Type | Unit of Measure | Value Set/  Concept Domain |
| <e.g., C [1..\*] | <Identifies the predicate and the if the predicate evaluates as true, then indicate whether mandatory, required or optional  e.g., Required if “exam type” is “LVG” (left ventriculogram)>  R: LVG | 60797005, SNOMED CT, “Cardiac Wall Motion”  <”+” = May be post-coordinated with priorityCode, methodCode, targetSiteCode . See HL7 V3. Include a value directly or include a link to a value set, if applicable.>  e.g., + targetSiteCode from 1.2.840.10008.6.1.219 DICOM CID 3718 Myocardial Wall Segments in Projection | CD | n/a unless the Data Type is PQ or IVL<PQ> | <include link to value set, e.g., 1.3.6.1.4.1.19376.1.4.1.5.20 Wall motion  OR, include value directly as e.g.,  <The Observation Value may also have a post-coordinated interpretation such as:>  +interpretationCode  +negationInd > |
| <e.g., C [1..\*] | R: SPECT, TTE, TEE, CMR  O:CCTA | 60797005, SNOMED CT, “Cardiac Wall Motion”  + targetSiteCode from 1.2.840.10008.6.1.218 DICOM CID 3717 Myocardial Wall Segments | CD | n/a | UV\_WallMotion > |

##### 6.3.4.E.2 Simple Observation (wall morphology) Constraints

<Describe constraints; refer to other Specification Document, condition, or other info. This specification may include more information on conditions or cardinality, additions elements, data mappings, or data types, or other information.>

<Can be in a tabular format or textual description.>

<Delete the example below prior to publishing for Public Comment.>

<e.g., The conditional entries specified in this table SHALL be present based on the exam type as specified in the CDA Header in the documentationOf / serviceEvent / code element.>

| Opt and Card | Condition | observation/code | Data Type | Unit of Measure | Value Set/  Concept Domain |
| --- | --- | --- | --- | --- | --- |
| <e.g., C [1..\*] | R: Cath with LVG | 72724002, SNOMED CT, “Morphology findings”  + targetSiteCode from 1.2.840.10008.6.1.219 DICOM CID 3718 Myocardial Wall Segments in Projection | CD | n/a | 1.3.6.1.4.1.19376.1.4.1.5.19 Myocardium Assessments> |
| <e.g., C [1..\*] | R: SPECT, echo, CMR  O:CCTA | 72724002, SNOMED CT, “Morphology findings”  + targetSiteCode from 1.2.840.10008.6.1.218 DICOM CID 3717 Myocardial Wall Segments | CD | n/a | UV\_MyocardiumAssessments> |

<e.g., The observation/value MAY be a null flavor.>

<e.g., morphological assessment observation MAY have a subsidiary Severity observation (templateID 1.3.6.1.4.1.19376.1.5.3.1.4.1 [PCC TF-2]).>

**### End Tabular Format - Entry**

**### Begin Discrete Conformance Format – Entry**

<An example is provided to demonstrate the desired consistent use and format. Delete this example prior to publication for Public Comment. The statements must be numbered, begin with SHALL/SHOULD/MAY identify the cardinality using [n..n], the name of the element, and a subitem which described the value or source of the information.>

##### <e.g.,6.3.4.E Result Observation - Cardiac

[observation: templateId 1.3.6.1.4.1.19376.1.4.1.4.16 (open)]

A result observation is a clinical statement that a clinician has noted during the Cath Lab procedure. This entry is used to describe the specific procedure findings that were observed during the specific Cath Lab procedure.

The specific result observations are defined in 1.3.6.1.4.1.19376.1.4.1.5.38 Procedure Findings Constraints/ValueSet.

1. SHALL contain exactly one [1..1] @classCode="OBS" Observation (CodeSystem: HL7ActClass 2.16.840.1.113883.5.6) (CONF:7130).
2. SHALL contain exactly one [1..1] @moodCode="EVN" Event (CodeSystem: ActMood 2.16.840.1.113883.5.1001) (CONF:7131).
3. SHALL contain exactly one [1..1] templateId (CONF:7136) such that it
   1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.4.2" (CONF:9138).
4. SHALL contain at least one [1..\*] id (CONF:7137).
   1. The first id represents this specific globally unique result observation.
   2. The second id represents the lesion ID which should be an assigned numeric code that identifies lesions within a specific targetSiteCode.This lesion ID is used to link lesion specific data in this Result Observation – Cardiac with Procedure Activity Procedure - Cardiac.
5. SHALL contain exactly one [1..1] code (CONF:7133).
   1. SHOULD be from LOINC (CodeSystem: 2.16.840.1.113883.6.1) or SNOMED CT (Value Set: 1.3.6.1.4.1.19376.1.4.1.5.38) (CONF:7166-CRC).
6. SHOULD contain zero or one [0..1] text (CONF:7138).
   1. The text, if present, SHOULD contain zero or one [0..1] reference/@value (CONF:7139).
      1. This reference/@value SHALL begin with a '#' and SHALL point to its corresponding narrative (using the approach defined in CDA Release 2, section 4.3.5.1) (CONF:9119).
7. SHALL contain exactly one [1..1] statusCode="completed" Completed (CodeSystem: ActStatus 2.16.840.1.113883.5.14) (CONF:7134).
8. SHALL contain exactly one [1..1] effectiveTime (CONF:7140).
   1. represents clinically effective time of the measurement, which may be when the measurement was performed (e.g., a BP measurement), or may be when sample was taken (and measured some time afterwards) (CONF:7141).
9. SHALL contain exactly one [1..1] value with @xsi:type="ANY" (CONF:7143).
10. SHOULD contain zero or more [0..\*] interpretationCode (CONF:7147).
11. MAY contain zero or one [0..1] methodCode (CONF:7148).
12. MAY contain zero or one [0..1] targetSiteCode (CONF:7153).
    1. The targetSiteCode, if present, SHALL contain exactly one [1..1] code where the @code SHALL be selected from ValueSet Body Site 1.3.6.1.4.1.19376.1.4.1.5.32 STATIC (CONF:CRC).
13. MAY contain zero or one [0..1] author (CONF:7149).
14. SHOULD contain zero or more [0..\*] referenceRange (CONF:7150).
    1. The referenceRange, if present, SHALL contain exactly one [1..1] observationRange (CONF:7151).
       1. This observationRange SHALL NOT contain [0..0] code (CONF:7152).
15. SHOULD contain zero or one [0..1] entryRelationship (CONF:CRC-xxx) such that it
    1. SHALL contain exactly one [1..1] @typeCode="SUBJ" Has subject (CodeSystem: HL7ActRelationshipType 2.16.840.1.113883.5.1002) (CONF:CRC-xxx).
    2. SHALL contain exactly one [1..1] @inversionInd="true" TRUE (CONF:CRC-xxx).
    3. SHALL contain exactly one [1..1] Severity Observation (2.16.840.1.113883.10.20.22.4.8) (CONF:CRC-xxx).

<observation classCode="OBS" moodCode="EVN">

<templateId root="1.3.6.1.4.1.19376.1.4.1.4.16"/>

<!-- Result Observation template -->

<id root="c6f88321-67ad-11db-bd13-0800200c9a66"/>

<!-- This second ID represents the lesion ID -->

<id root="107c2dc0-67a5-11db-bd13-0800200c9a66" extension="1"/>

<code code="233970002"

codeSystem="2.16.840.1.113883.6.96"

codeSystemName="SNOMED CT"

displayName="Post procedure stenosis"/>

<text><reference value="1"/></text>

<statusCode code="completed"/>

<effectiveTime value="19991114"/>

<targetSiteCode code="41879009" codeSystem="1.3.6.1.4.1.19376.1.4.1.5.32"

displayName="Distal RCA"/>

<value xsi:type="PQ" value="0" unit="%"/>

<interpretationCode code="N" codeSystem="2.16.840.1.113883.5.83"/>

</observation>

e.g., Figure 6.3.4.E-1: Result observation example >

**### End Discrete Conformance Format - Entry**

## 6.4 Section not applicable

Not applicable

<This heading is not currently used in a CDA document and remains here for section numbering integrity. Do not remove it or renumber sections following it. >

Add to Section 6.5 Value Sets

## 6.5 <Domain Acronym> Value Sets and Concept Domains

<Replicate the Value Set 6.5.x section as many times as needed for this supplement.>

<It is preferable to use tabular format. Add notes as needed. Be aware of potential national licensing issues of coding schemes.>

### 6.5.x <Value Set Name/Concept Domain Name> <oid>

<Add description or clarifications here if necessary.>

|  |  |
| --- | --- |
| Coding Scheme  Concept | <Coding Scheme Name> |
|  |  |
|  |  |
|  |  |
|  |  |

Note: <as necessary, applicable>

OR

|  |
| --- |
| <Concept Domain Name> |
|  |
|  |
|  |
|  |

<Delete the example below prior to publication for Public Comment.>

### <e.g.,6.5.1 Drug Classes Used in Cardiac Procedure 1.3.6.1.4.1.19376.1.4.1.5.15

| Coding Scheme  Concept | SNOMED CT | NDF-RT |
| --- | --- | --- |
| Calcium channel blockers | 48698004 | N0000029119 |
| Beta-blockers | 33252009 | N0000029118 |
| Nitrates | 31970009 | N0000007647 |
| Aminophylline | 55867006 | N0000146397 |

Note: As described in Section 6.1.2.4, the selection of the appropriate coding system for use may be based on local policy or national regulation.

OR

### 6.5.1 UV\_CardiacProcedureDrugClasses

This Concept Domain holds a list of Drug Classes used in Cardiac Procedures. The concepts in this domain must be bound to a value set at implementation.

|  |
| --- |
| Concept Name |
| Calcium channel blockers |
| Beta-blockers |
| Nitrates |
| Aminophylline |

>

Appendices

*<Add any applicable Volume 3 appendices below.*

*<If there are no Volume 3 appendices, enter “Not applicable” and delete the Appendix A and Appendix B placeholder sections.>*

# Appendix A – <Appendix Title>

Appendix A text.

## A.1 <Title>

Appendix A.1 text.

### A.1.1 <Title>

Appendix A.1.1 text.

# Appendix B – <Appendix Title>

Appendix B text.

## B.1 <Title>

Appendix B.1 text.

### B.1.1 <Title>

Appendix B.1.1 text.

Volume 4 – National Extensions

Add appropriate Country section

# 4 National Extensions

4.I National Extensions for <Country Name or IHE Organization>

<A template for Volume 4 is included in this document for completeness; however, National Extensions are typically developed after a profile has been published for Trial Implementation. If you are developing a new profile for Public Comment, it is recommended that this section be marked “Not Applicable”.>

<Avoid using this section if you can, this is “only if absolutely necessary”. Differences add cost to implementation and testing and can reduce interoperability. Review carefully to determine if the national use case truly requires a difference in the profile mechanisms rather than just differences in system configuration.>

< National Extensions can add requirements above and beyond IHE, but **not** relax requirements. This would prevent Connectathon results based on national testing being recognized elsewhere. For more information, see <http://wiki.ihe.net/index.php?title=National_Extensions_Process>.>

The format of this section is not strongly specified due to the varying nature of national extensions. For an example of National Extensions, see RAD TF 4.>

4.I.1 Comment Submission

This national extension document was authored under the sponsorship and supervision of <sponsor name>, who welcome comments on this document and the IHE <country> initiative. Comments should be directed to:

<Name, organization, title, email address>

4.I.2 <Profile Name> <(Profile Acronym)>

<Add info or tables>

4.I.2.1<Profile Acronym> Value Set Binding for <Country Name or IHE Organization> Realm Concept Domains

*<This section defines the actual value sets and code systems for any coded concepts that were described by concept domains in the main profile and binds the value set to the coded concepts.>*

*<Add info or tables>*

*<Delete the example below prior to publication for Public Comment.>*

*<e.g.,*

4.I.2.1 <Profile Acronym> Value Set Binding for US Realm Concept Domains

| UV Concept Domain | US Realm Vocabulary Binding or Single Code Binding | Value Set OID |
| --- | --- | --- |
| UV\_CardiacProcedureDrugClasses | US\_CardiacProcedureDrugClasses | 1.3.6.1.4.1.19376.1.4.1.5.15 |

#### 4.I.2.1.1 US\_CardiacProcedureDrugClasses (1.3.6.1.4.1.19376.1.4.1.5.15)

|  |  |  |
| --- | --- | --- |
| Coding Scheme  Concept | SNOMED CT | NDF-RT |
| Calcium channel blockers | 48698004 | N0000029119 |
| Beta-blockers | 33252009 | N0000029118 |
| Nitrates | 31970009 | N0000007647 |
| Aminophylline | 55867006 | N0000146397 |

>

4.I.2.2<Profile Acronym> <Type of Change>

<Add info or tables>

4.I+1 National Extensions for <Country Name or IHE Organization>

<Repeat (and increment) the section above as needed for additional National Extensions>

Appendices

*<Add any applicable Volume 4 appendices below>*

*<If there are no Volume 4 appendices, enter “Not applicable”* *and delete the Appendix A and Appendix B placeholder sections.>*

# Appendix A – <Appendix Title>

Appendix A text.

## A.1 <Title>

Appendix A.1 text.

### A.1.1 <Title>

Appendix A.1.1 text.

# Appendix B – <Appendix Title>

Appendix B text.

## B.1 <Title>

Appendix B.1 text.

### B.1.1 <Title>

Appendix B.1.1 text.