Integrating the Healthcare Enterprise

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IHE Patient Care Coordination (PCC)

Technical Framework Supplement

**Labor and Delivery Profiles**

Trial Implementation

Date: August xx, 2010

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This page is standard language for all IHE supplements. The Introduction section following will list all other IHE documents that are modified by this supplement. This document is a supplement to the IHE Patient Care Coordination Technical Framework V5.0. The technical framework can be found at http://www.ihe.net/Technical\_Framework/index.cfm#pcc.

This and all IHE supplements are written as changes to a base document. The base document is normally one or more IHE Final Text documents. Supplements tell a technical editor and the reader how to modify the final text (additions, deletions, changes in wording). In order to understand this supplement, the reader needs to read and understand all of the base documents that are modified by this supplement.

In this supplement you will see “boxed” instructions similar to the following:

Replace Section X.X by the following:

These “boxed” instructions are for the author to indicate to the Volume Editor how to integrate the relevant section(s) into the overall Technical Framework.

This format means the reader has to integrate the base documents and the supplement. When the material in the supplement is considered ready for incorporation into the final text of the Technical Framework, the IHE committees will update the technical framework documents with the final text. Supplements are written in this format to avoid duplication material. This means that two IHE documents (one possibly final text, and the other a supplement) should not contain contradictory material.

Text in this document is not considered final for the Technical Framework. It becomes Final Text only after the IHE Patient Care Coordination Technical Committee ballots the supplement (after testing) and agrees that the material is ready for integration with the existing Technical Framework documents.

**It is submitted for Public Comment starting June 01, 2010.**

**Comments on this supplement may be submitted http://forums.rsna.org:**

1. Select the “IHE” forum
2. Select Patient Care Coordination Technical Framework
3. Select 2010 Supplements for Public Comment
4. Select Labor and Delivery Profiles

Please use the Public Comment Template provided there when starting your New Thread.

**Details about IHE may be found at:** www.ihe.net

**Details about the IHE Patient Care Coordination may be found at:** http://www.ihe.net/Domains/index.cfm

**Details about the structure of IHE Technical Frameworks and Supplements may be found at:** http://www.ihe.net/About/process.cfm and http://www.ihe.net/profiles/index.cfm

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## Introduction

This supplement is written for Public Comment. It is written as changes to the documents listed below. The reader should have already read and understood these documents:

1. [PCC Technical Framework Volume 1, Revision 5.0](http://www.ihe.net/Technical_Framework/index.cfm#PCC)
2. [PCC Technical Framework Volume 2, Revision 5.0](http://www.ihe.net/Technical_Framework/index.cfm#PCC)

This supplement also references other documents[[1]](#footnote-1). The reader should have already read and understood these documents:

1. [IT Infrastructure Technical Framework Volume 1, Revision 6.0](http://www.ihe.net/Technical_Framework/index.cfm#IT)
2. [IT Infrastructure Technical Framework Volume 2, Revision 6.0](http://www.ihe.net/Technical_Framework/index.cfm#IT)
3. [IT Infrastructure Technical Framework Volume 3, Revision 6.0](http://www.ihe.net/Technical_Framework/index.cfm#IT)
4. [The Patient Identifier Cross-Reference (PIX) and Patient Demographic Query (PDQ) HL7 v3 Supplement to the IT Infrastructure Technical Framework.](http://www.ihe.net/Technical_Framework/index.cfm#IT)
5. HL7 and other standards documents referenced in Volume 1 and Volume 2
6. Dilbert 2.0: 20 Years of Dilbert by Scott Adams, ISBN-10: 0740777351, ISBN-13: 978-0740777356

### How to read the Labor and Delivery Profiles supplement

This supplement contains 3 content profiles – Labor and Delivery History and Physical (LDHP), Labor and Delivery Summary (LDS), and Maternal Discharge Summary (MDS). Labor and Delivery Record (LDR) is no longer a profile as it has been subsumed by Perinatal Workflow (PW) profile.

Please see the below documents that will need to be referenced to fully understand the profiles in this supplement. Each document has a short description describing what is contained.

1. **Perinatal Workflow (PW):** makes use of the antepartum, labor and delivery, postpartum, and newborn delivery profiles (some are in this supplement and many are in other supplements).
2. **Content Modules Supplement:** This document contains all PCC Section Templates, Entry Templates, and Value Sets that are NOT in Final Text (that is, they are not in the Technical Framework Volume 2).
3. **PCC Technical Framework Volume 2, Revision 5.0 (published August 2008):** This contains all PCC Section Templates, Entry Templates and Value Sets (among other things) that ARE in Final Text.

### How to Access the Reference Material

To access Perinatal Workflow and Content Modules supplements refer to the same web page from which you accessed this supplement. In the event that has left your memory please follow these instructions:

* + Navigate to <http://www.ihe.net>
  + Click “Get Involved” on the top menu
  + Select “Public Comment”
  + Click the “Patient Care Coordination” link

To access the PCC Technical Framework Volume 2 Revision 5.0 follow this link: <http://www.ihe.net/Technical_Framework/upload/IHE_PCC_TF_50_Vol_2_2009-08-10.pdf>

## Open Issues and Questions

1. How should grouping be handled for sections that are reused from other profiles? For example several APHP sections are reused in LDHP and this should be called out somewhere, probably in the grouping section, but existing profiles use of the groupings section is not clear or consistent so a new table format should be explored. This could also be put in an appendix since it applies to several related profiles.
2. In sections X.7, Y.7, Z.7 (mappings to PCC Templates) the origin of the groups of data elements needs to be called out to show that these data did in fact originate from some sort of standard or at the very least clinical consensus within PCC committee.

In the Newborn Discharge Summary (NDS) and Post-Partum Visit Summary (PPVS) profiles, the Labor and Delivery Events section is described much more inclusively than the description in this profile. Specific data elements are now distributed between various sections rather than all grouped in the Labor and Delivery Events section. For example, medications administered is now a separate section, as is maternal complications which are now included in the problems section. Episiotomies, c-sections etc are now in the procedures and interventions subsection of Labor and Delivery Events. The content of these sections will need to be reconciled between the two profiles.

MCH is dependent on LDS to provide a disposition of the newborn upon transfer from the birthing suite. Possible value sets may include: transfer to Newborn ICU; transfer to well newborn nursery; transfer to tertiary facility. This has been captured in MDS as newborn disposition at maternal discharge, however MCH needs this data at the time of transfer from the birthing suite. This still needs to be addressed.

## Closed Issues

Volume 1 – Profiles

Add the following to section 1.1.5

### 1.1.5 Copyright Permissions

Add the following to section 2.5

## 2.5 Dependencies of the PCC Integration Profiles

|  |  |  |  |
| --- | --- | --- | --- |
| <Profile Name> | <?> | <?> | <-> |

Add the following to section 2.7

## 2.7 History of Annual Changes

Add Section X

# X Labor and Delivery History and Physical Content Profile (LDHP)

Labor and Delivery History and Physical is a content profile that defines the structure of the data that is often collected during the initial admission to the birthing facility. It includes, but is not limited to demographics, histories, allergies, physical examinations, vital signs, and care plans.

## X.1 Purpose and Scope

The information collected during labor, delivery and the immediate postpartum period is very important to follow-up care for both mother and infant, whether the follow-up care is provided in an inpatient or outpatient facility. A physician's recommendation for a follow-up hematocrit test or evaluation of the incision in the office may be noted in the Labor and Delivery Summary or in the Maternal Discharge Summary. These documents must be available in both inpatient and outpatient settings.

Pertinent maternal information includes, but is not limited to, delivery type; labor type; anesthesia type; labor, delivery and postpartum complications; and specific maternal information such as medications, laboratory test results, allergies and plans for contraception. Pertinent neonatal information includes, but is not limited to, delivery method, gender, birth time, birth weight, gestational age at delivery, APGAR scores, and medications received in the delivery room including immunizations.

## X.2 Process Flow

### X.2.1 Use Cases

Change referenced section numbering when merged into technical framework

For applicable use cases see Perinatal Workflow section X.2.1.

### X.2.2 Diagrams

Change referenced section numbering when merged into technical framework

For applicable diagrams see Perinatal Workflow section X.2.2.

## X.3 Actors/Transactions

There are two actors in this profile, the Content Creator and the Content Consumer. Content is created by a Content Creator and is to be consumed by a Content Consumer. The sharing or transmission of content from one actor to the other is addressed by the appropriate use of IHE profiles described below, and is out of scope of this profile. A Document Source or a Portable Media Creator may embody the Content Creator Actor. A Document Consumer, a Document Recipient, or a Portable Media Importer may embody the Content Consumer Actor. The sharing or transmission of content or updates from one actor to the other is addressed by the use of appropriate IHE profiles described in the section on Content Bindings with XDS, XDM and XDR. in PCC TF\_2:4.1



Figure X.3-1 Actor Diagram

### X.3.1 Requirements of Actors

## X.4 Options

Table X.4-1 Labor and Delivery History and Phyiscal Options

|  |  |  |
| --- | --- | --- |
| Actor | Option | Section |
| Content Consumer | View Option (See Note 1)  Document Import Option (See Note 1) Section Import Option (See Note 1) Discrete Data Import Option (See Note 1) | PCC TF-2: 3.0.1  PCC TF-2: 3.0.2 PCC TF-2: 3.0.3 PCC TF-2: 3.0.4 |
| Content Creator | No options defined |  |

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

## X.5 Groupings

Groupings are needed to represent which templates are required from other content profiles and will be added in future work.

## X.6 Security Considerations

## X.7 Content Modules

Table X.7‑1 Labor and Delivery History and Physical Content Modules

| Datum | PCC Template Name |
| --- | --- |
| Demographics | Header Modules  (See Note 1) |
| Chief Complaint | Chief Complaint  (See Note 1) |
| Problem List | Problems |
| Admission Medication History | Admission Medication History |
| Pregnancy History | Pregnancy History  (See Note 1) |
| HPI or Intermin Medical History | History of Present Illness |
| Medical History | History of Past Illness (See Note 1) |
| Social History | Coded Social History  (See Note 1) |
| Medical History – Relevant Family History | Coded Family Medical History  (See Note 1) |
| Allergies | Allergies and Other Adverse Reactions  (See Note 1) |
| Menstrual History/Symptoms Since LMP | Review of Systems  (See Note 1) |
| Genetic Screening/Teratology Counseling | Coded Family History Medical History  (See Note 1) |
| Infection History | Coded History of Infection  (See Note 1) |
| Initial Phyiscal Examination | Coded Physical Exam  (See Note 1) |
| Vital Signs | Coded Vital Signs  (See Note 1) |
| Pain Assessment | Pain Assessment Panel |
| Diagnostic Findings | Prenatal Events: Coded Results  (See Note 1) |
| Antenatal Test Results | Coded Antenatal Testing and Surveillance |
| Surgical History | History of Surgical Procedures  (See Note 1) |
| Prenatal Events | Prenatal Events |
| Estimated Delivery Date | Estimated Delivery Date |
| Care Plan | Care Plan |

Note 1: This template is part of Antepartum History and Physical

## X.8 References

This profile contains different summaries based on data elements collected from different forms originating from various organizations in the United States and Europe. The generic forms used to build this profile are:

* Demographic information about the mother, the father and the child
* General information about the family
* Admission Assessment for Labor and Delivery
* Transport Summary during pregnancy (if any)
* Antepartum Summary
* Labor & Delivery Summary (combined with the Newborn Birth Summary while in the birth room)
* Maternal Discharge Summary
* Patient Plan of Care Profile

These forms and data elements were collected with the assistance of the following organizations:

|  |  |
| --- | --- |
| ACOGAR | [American College of Obstetricians and Gynecologists (ACOG), Antepartum Record](http://www.acog.org" \o "http://www.acog.org) |
| AUDIPOG | [Association des Utilisateurs de Dossiers Informatisés en Périnatalogie, Obstétrique et Gynécologie](http://www.audipog.net/index.php?lang=en) |
| Dossier obstétrical | [Fédération suisse des sages-femmes 2008](http://www.hebamme.ch/fr/heb/shv/tools.cfm) |
| UHIN | Utah Health Information Network |
| IH | Intermountain Healthcare |

# Y Labor and Delivery Summary Content Profile (LDS)

Labor and Delivery Summary is a content profile that defines the structure of the data that is often collected during the labor and delivery period at the birthing facility. It includes, but is not limited to demographics, histories, allergies, physical examinations, vital signs, and newborn delivery information.

## Y.1 Purpose and Scope

The information collected during labor, delivery, and the immediate postpartum period is very important to follow-up care for both mother and infant whether the follow-up care is provided in an inpatient or outpatient facility. A physician's recommendation for a follow-up hematocrit test or evaluation of the incision in the office may be noted in the Labor and Delivery Summary or in the Maternal Discharge Summary. These documents must be available in both inpatient and outpatient settings.

Pertinent maternal information includes, but is not limited to, delivery type; labor type; anesthesia type; labor, delivery and postpartum complications; and specific maternal information such as medications, laboratory test results, allergies, and plans for contraception. Pertinent neonatal information includes, but is not limited to, delivery method, gender, birth time, birth weight, gestational age at delivery, APGAR scores, and medications received in the delivery room including immunizations.

## Y.2 Process Flow

### Y.2.1 Use Cases

Change referenced section numbering when merged into technical framework

For applicable use cases see Perinatal Workflow section X.2.1.

### Y.2.2 Diagrams

Change referenced section numbering when merged into technical framework

For applicable diagrams see Perinatal Workflow section X.2.2.

## Y.3 Actors/Transactions

There are two actors in this profile, the Content Creator and the Content Consumer. Content is created by a Content Creator and is to be consumed by a Content Consumer. The sharing or transmission of content from one actor to the other is addressed by the appropriate use of IHE profiles described below, and is out of scope of this profile. A Document Source or a Portable Media Creator may embody the Content Creator Actor. A Document Consumer, a Document Recipient, or a Portable Media Importer may embody the Content Consumer Actor. The sharing or transmission of content or updates from one actor to the other is addressed by the use of appropriate IHE profiles described in the section on Content Bindings with XDS, XDM and XDR. in PCC TF\_2:4.1



Figure Y.3-1 Actor Diagram

### Y.3.1 Requirements of Actors

## Y.4 Options

Table Y.4-1 Labor and Delivery Summary Options

|  |  |  |
| --- | --- | --- |
| Actor | Option | Section |
| Content Consumer | View Option (See Note 1)  Document Import Option (See Note 1) Section Import Option (See Note 1) Discrete Data Import Option (See Note 1) | PCC TF-2: 3.0.1  PCC TF-2: 3.0.2 PCC TF-2: 3.0.3 PCC TF-2: 3.0.4 |
| Content Creator | No options defined |  |

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

## Y.5 Groupings

Groupings are needed to represent which templates are required from other content profiles and will be added in future work.

## Y.6 Security Considerations

## Y.7 Content Modules

Table Y.7‑1 Labor and Delivery Summary Content Modules

| Data Element | PCC Template Name |
| --- | --- |
| Demographics | Header Modules  (See Note 1) |
| Admitting Diagnosis | Hospital Admission Diagnosis |
| History of Medications | Admission Medication History |
| Chief Complaint | Chief Complaint |
| Arrival Mode | Transport Mode |
| Admission Assessment and Plan | Assessment and Plan |
| Problem List | Problems |
| Maternal and Fetal Labs | Coded Results |
| Interim Medical History | History of Present Illness |
| Past Medical History | History of Past Illness |
| Advance Directives | Coded Advance Directives |
| Patient’s Birth Plan | Birth Plan |
| Allergies | Allergies and Other Adverse Reactions |
| Maternal Physical Exam | Coded Physical Exam |
| Estimated Date of Delivery determined at admission | Estimated Delivery Date  (See Note 1) |
| Medications Administered | Medications Administered |
| Intravenous Fluids | Intravenous Fluids Administered |
| Intake and Output (excludes estimated blood loss) | Intake and Output |
| Blood Transfusions Received in Labor and Delivery | History of Blood Transfusions |
| Surgical History | History of Surgical Procedures |
| Detailed Information of Labor and Delivery | Labor and Delivery Events |
| Procedures and Interventions during Labor and Delivery | Labor and Delivery Events: Procedures and Interventions |
| Labor, Delivery and Operative Complications | Problems |
| Outcomes Related to the Labor and Delivery Process | Labor and Delivery Events: Event Outcomes |
| Maternal Blood Loss | Estimated Blood Loss |
| Antenatal Tests Performed while in Labor and Delivery | Coded Antenatal Testing and Surveillance |
| Pain Assessment | Pain Assessment Panel |
| Physical Exam Findings | Newborn Delivery Information: Coded Physical Exam |
| Birth Date/Time | Newborn Delivery Information |
| Newborn Complications | Newborn Delivery Information: Problems |
| Newborn Output in Delivery | Intake and Output |
| Cord Blood Tests | Coded Results |
| Newborn Medications Given in Birthing Suite | Newborn Delivery Information: Medications |
| Newborn Procedures or Interventions in Birthing Suite | Newborn Delivery Information: Procedures and Interventions |

Note 1: This template is part of Labor and Delivery History and Physical

## Y.8 References

This profile contains different summaries based on data elements collected from different forms originating from various organizations in the United States and Europe. The generic forms used to build this profile are:

* Demographic information about the mother, the father and the child
* General information about the family
* Admission Assessment for Labor and Delivery
* Transport Summary during pregnancy (if any)
* Antepartum Summary
* Labor & Delivery Summary (combined with the Newborn Birth Summary while in the birth room)
* Maternal Discharge Summary
* Patient Plan of Care Profile

These forms and data elements were collected with the assistance of the following organizations:

|  |  |
| --- | --- |
| ACOGAR | [American College of Obstetricians and Gynecologists (ACOG), Antepartum Record](http://www.acog.org" \o "http://www.acog.org) |
| AUDIPOG | [Association des Utilisateurs de Dossiers Informatisés en Périnatalogie, Obstétrique et Gynécologie](http://www.audipog.net/index.php?lang=en) |
| Dossier obstétrical | [Fédération suisse des sages-femmes 2008](http://www.hebamme.ch/fr/heb/shv/tools.cfm) |
| UHIN | Utah Health Information Network |
| IH | Intermountain Healthcare |

# Z Maternal Discharge Summary Content Profile (MDS)

Maternal Discharge Summary is a content profile that defines the structure of the data that is often collected post delivery until discharge from the birthing facility. It includes, but is not limited to demographics, medications, laboratory results, newborn delivery information, patient education, and outcomes.

## Z.1 Purpose and Scope

The information collected during labor, delivery, and the immediate postpartum period is very important to follow-up care for both mother and infant whether the follow-up care is provided in an inpatient or outpatient facility. A physician's recommendation for a follow-up hematocrit test or evaluation of the incision in the office may be noted in the Labor and Delivery Summary or in the Maternal Discharge Summary. These documents must be available in both inpatient and outpatient settings.

Pertinent maternal information includes, but is not limited to, delivery type; labor type; anesthesia type; labor, delivery and postpartum complications; and specific maternal information such as medications, laboratory test results, allergies, and plans for contraception. Pertinent neonatal information includes, but is not limited to, delivery method, gender, birth time, birth weight, gestational age at delivery, APGAR scores, and medications received in the delivery room including immunizations.

## Z.2 Process Flow

### Z.2.1 Use Cases

Change referenced section numbering when merged into technical framework

For applicable use cases see Perinatal Workflow section X.2.1.

### Z.2.2 Diagrams

Change referenced section numbering when merged into technical framework

For applicable diagrams see Perinatal Workflow section X.2.2.

## Z.3 Actors/Transactions

There are two actors in this profile, the Content Creator and the Content Consumer. Content is created by a Content Creator and is to be consumed by a Content Consumer. The sharing or transmission of content from one actor to the other is addressed by the appropriate use of IHE profiles described below, and is out of scope of this profile. A Document Source or a Portable Media Creator may embody the Content Creator Actor. A Document Consumer, a Document Recipient, or a Portable Media Importer may embody the Content Consumer Actor. The sharing or transmission of content or updates from one actor to the other is addressed by the use of appropriate IHE profiles described in the section on Content Bindings with XDS, XDM and XDR. in PCC TF\_2:4.1



Figure Z.3-1 Actor Diagram

### Z.3.1 Requirements of Actors

## Z.4 Options

Table Z.4-1 Maternal Discharge Summary Options

|  |  |  |
| --- | --- | --- |
| Actor | Option | Section |
| Content Consumer | View Option (See Note 1)  Document Import Option (See Note 1) Section Import Option (See Note 1) Discrete Data Import Option (See Note 1) | PCC TF-2: 3.0.1  PCC TF-2: 3.0.2 PCC TF-2: 3.0.3 PCC TF-2: 3.0.4 |
| Content Creator | No options defined |  |

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

## Z.5 Groupings

Groupings are needed to represent which templates are required from other content profiles and will be added in future work.

## Z.6 Security Considerations

## Z.7 Content Modules

Table Z.7‑1 Maternal Discharge Summary Content Modules

| Data Element | PCC Template Name |
| --- | --- |
| Demographics | Header Modules  (See Note 1) |
| Discharge Date/Time | Header Module |
| Admission Diagnosis | Hospital Admission Diagnosis |
| Problem List | Problems |
| Discharge Diagnosis | Discharge Diagnosis |
| Discharge Disposition | Discharge Disposition |
| Discharge Method | Transport Mode |
| Condition on Discharge | Discharge Status |
| Allergies | Allergies and Other Adverse Reactions |
| Events during the hospitalization | Hospital Course |
| Advance Directive | Coded Advance Directives  (See Note 1) |
| Medications prescribed at discharge | Hospital Discharge Medications |
| Imaging Reports | Coded Hospital Studies Summary |
| Pain Assessment | Pain Assessment Panel |
| Skin Assessment | Braden Score |
| Post-Partum Complications | Active Problems |
| Discharge Diet | Post-Partum Treatment: Discharge Diet |
| Medications Administered | Post-Partum Treatment: Medications Administered |
| Hgb/Hct | Post-Partum Treatment: Coded Results |
| Postpartum Procedures | Post-Partum Treatment: Procedures and Interventions |
| Post-Partum Plan of Care | Post-Partum Treatment: Care Plan |
| Immunizations Recommendations | Immunization Recommendations |
| Immunizations Given | Post-Partum Treatment: Immunizations |
| Type of IV Fluids Received | Intravenous Fluids Administered |
| Blood loss after the immediate delivery time-frame | Estimated Blood Loss |
| Number of blood transfusions (units) patient received | Transfusion History |
| Teaching/Instructions Given and Patient Verbalizes Understanding | Patient Education |
| Delivery Type (e.g. vaginal, cesarean ssection,vaginal birth after cesarean section and type of incision if c-section | Labor and Delivery Events: Procedures and Interventions |
| Risk Screening | Coded Social History |
| Discharge Activity | Provider Orders |
| Lactation Consultation | Consultations |
| First and Last Name of Baby at Birth | NDS: Header Module |
| First and Last Name of Baby at Discharge | NDS: Header Module |
| Baby’s Unique IDENTIFIER | NDS: Header Module |
| Baby’s Sex/Gender | LDS: Newborn Delivery Information |
| Circumcision (if Male) | NDS: Procedures and Interventions |
| Birth Weight | LDS: Newborn Delivery Information |
| Pediatrician’s Name | NDS: Care Plan |
| Discharge Disposition(baby) | Newborn Status at Maternal Discharge |

Note 1: This template is part of Labor and Delivery Summary

## Z.8 References

This profile contains different summaries based on data elements collected from different forms originating from various organizations in the United States and Europe. The generic forms used to build this profile are:

* Demographic information about the mother, the father and the child
* General information about the family
* Admission Assessment for Labor and Delivery
* Transport Summary during pregnancy (if any)
* Antepartum Summary
* Labor & Delivery Summary (combined with the Newborn Birth Summary while in the birth room)
* Maternal Discharge Summary
* Patient Plan of Care Profile

These forms and data elements were collected with the assistance of the following organizations:

|  |  |
| --- | --- |
| ACOGAR | [American College of Obstetricians and Gynecologists (ACOG), Antepartum Record](http://www.acog.org" \o "http://www.acog.org) |
| AUDIPOG | [Association des Utilisateurs de Dossiers Informatisés en Périnatalogie, Obstétrique et Gynécologie](http://www.audipog.net/index.php?lang=en) |
| Dossier obstétrical | [Fédération suisse des sages-femmes 2008](http://www.hebamme.ch/fr/heb/shv/tools.cfm) |
| UHIN | Utah Health Information Network |
| IH | Intermountain Healthcare |

Volume 2 – Transactions and Content Modules

# 5.0 Namespaces and Vocabularies

|  |  |  |
| --- | --- | --- |
| codeSystem | codeSystemName | Description |
|  |  |  |

## 5.1 IHE Format Codes

|  |  |  |  |
| --- | --- | --- | --- |
| Profile | Format Code | Media Type | Template ID |
| Labor and Delivery History and Physical (LDHP) | urn:ihe:pcc:ldhp:2009 | text/xml | 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.1 |
| Labor and Delivery Summary (LDS) | urn:ihe:pcc:lds:2009 | text/xml | 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2 |
| Maternal Discharge Summary (MDS) | urn:ihe:pcc:mds:2009 | text/xml | 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.3 |

# 6 PCC Content Modules

## 6.2 Folder Content Modules

See Perinatal Workflow section 6.2.L.

## 6.3 HL7 Version 3.0 Content Modules

### 6.3.1 CDA Document Content Modules

Add section 6.3.1.A

#### 6.3.1.A Labor and Delivery History and Physical 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.1

The Labor and Delivery History and Physical (LDHP) content profile represents the patient’s history and physical performed during admission to the birthing facility. The LDHP is a Medical Summary and inherits all header constraints from Medical Summary. It also uses parts of the Antepartum History and Physical where needed.

##### 6.3.1.A.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:pcc:ldhp:2009**

##### 6.3.1.A.2 LOINC Code

The LOINC code for this document is **57056-4** Labor and Delivery admission history and physical

##### 6.3.1.A.3 Standards

|  |  |
| --- | --- |
| CCD | ASTM/HL7 Continuity of Care Document |
| CDAR2 | [HL7 CDA Release 2.0](http://www.hl7.org/documentcenter/private/standards/cda/r2/cda_r2_normativewebedition.zip) |
| ACOG AR | [American College of Obstetricians and Gynecologists (ACOG), Antepartum Record](http://www.acog.org" \o "http://www.acog.org) |
| LOINC | [Logical Observation Identifiers, Names and Codes](http://www.regenstrief.org/medinformatics/loinc/) |
| SNOMED | [Systemized Nomenclature for Medicine](http://www.snomed.org) |
| CDTHP | [CDA for Common Document Types History and Physical Notes (DSTU)](http://www.hl7.org/dstucomments/index.cfm) |

##### 6.3.1.A.4 Specification

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

* IHE Patient Care Coordination Volume 2: Final Text
* IHE PCC Content Modules 2010-2011 Supplement

Table 6.3.1.A.4-1 Labor and Delivery History and Physical Specification

| Template Name | Opt | Section Template Id | Value Set Template Id |
| --- | --- | --- | --- |
| Chief Complaint  (See Note 1) | R | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1 | N/A |
| History of Present Illness  (See Note 1) | R | 1.3.6.1.4.1.19376.1.5.3.1.3.4 | N/A |
| History of Past Illness  (See Note 1) | R | 1.3.6.1.4.1.19376.1.5.3.1.3.8 | 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.1 |
| Coded History of Infection  (See Note 1) | R | 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1 | 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.6 |
| Problems | R | 1.3.6.1.4.1.19376.1.5.3.1.3.6 | N/A |
| Pregnancy History  (See Note 1) | R | 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4 | N/A |
| Coded [Social History](#_1.3.6.1.4.1.19376.1.5.3.1.3.16.htm)  (See Note 1)  This section shall include the patient’s social history including tobacco, alcohol and drug use (current or prior) as well as other environmental exposures. | R | 1.3.6.1.4.1.19376.1.5.3.1.3.16.1 | 1.3.6.1.4.1.19376.1.5.3.1.4.13.4 |
| Coded Family Medical History  (See Note 1) | R | 1.3.6.1.4.1.19376.1.5.3.1.3.15 | 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.4 |
| Admission Medication History | R | 1.3.6.1.4.1.19376.1.5.3.1.3.20 | N/A |
| Allergies and Other Adverse Reactions  (See Note 1) | R | 1.3.6.1.4.1.19376.1.5.3.1.3.13 | N/A |
| Review of Systems  (See Note 1) | R | 1.3.6.1.4.1.19376.1.5.3.1.3.18 | 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.5 |
| Coded Physical Exam  (See Note 1) | R | 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 | N/A |
| Vital Signs  (See Note 1) | C | 1.3.6.1.4.1.19376.1.5.3.1.3.25 | N/A |
| History of Surgical Procedures  (See Note 1) | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2 | N/A |
| Prenatal Events | R | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.2 | N/A |
| Prenatal Events: Coded Results  (See Note 1) | R | 1.3.6.1.4.1.19376.1.5.3.1.3.28 | N/A |
| Estimated Delivery Date | R | 1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1 | N/A |
| Care Plan | R2 | 1.3.6.1.4.1.19376.1.5.3.1.3.31 | N/A |
| Coded Antenatal Testing and Surveillance | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1 | N/A |
| Pain Assessment Panel | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4 | N/A |

Note 1: This template is part of Antepartum History and Physical and should be pulled from there when available.

##### 6.3.1.A.5 Conformance

CDA Release 2.0 documents that conform to the requirements of this content module shall indicate their conformance by the inclusion of the appropriate <templateId> elements in the header of the document. This is shown in the sample document below. A CDA Document may conform to more than one template. This content module inherits from the History and Physical content module, and so must conform to the requirements of that template as well, thus all <templateId> elements shown in the example below shall be included.

<ClinicalDocument xmlns='urn:hl7-org:v3'>

<typeId extension="POCD\_HD000040" root="2.16.840.1.113883.1.3"/>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.2'/><!--Medical Summary-->

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.1.4'/><!--History and Physical-->  
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.1.1'/><!--Antepartum History and Physical-->

 <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.1.1'/><!--Labor and Delivery History and Physical-->

<id root=' ' extension=' '/>

<code code='57056-4' displayName='Labor and delivery admission history and physical'

codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>

<title>Labor and Delivery Record History and Physical</title>

<effectiveTime value='20080601012005'/>

<confidentialityCode code='N' displayName='Normal'

codeSystem='2.16.840.1.113883.5.25' codeSystemName='Confidentiality' />

<languageCode code='en-US'/>

 :

<component><structuredBody>

 <component>

<section>

<templateId root='[1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1](#_1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1.htm)'/>

<!-- Required Chief Complaint Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='[1.3.6.1.4.1.19376.1.5.3.1.3.4](#_1.3.6.1.4.1.19376.1.5.3.1.3.4.htm)'/>

<!-- Required History of Present Illness Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.8'/>

<!-- Required History of Past Illness Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.1.1.1'/>

<!-- Required Coded History of Infection Section content -->

</section>

</component>

 <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.6'/>

<!-- Required Problems Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4'/>

<!-- Required Pregnancy History Section content -->

</section>

</component>

 <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.16.1'/>

<!-- Required Coded Social History Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.15'/>

<!-- Required Coded Family Medical History Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.20'/>

<!-- Required Admission Medication History Section content -->

</section>

</component>

<component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.13'/>

<!-- Required Allergies and Other Adverse Reactions Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.18'/>

<!-- Required Review of Systems Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1'/>

<!-- Required Coded Physical Exam Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.25'/>

<!-- Conditional Vital Signs Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2'/>

<!-- Required if known History of Surgical Procedures Section content -->

</section>

</component>

<component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.2'/>

<!-- Required Prenatal Events Section content -->

</section>

</component>  
 <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.11.2.2.1'/>

<!-- Required Estimated Delivery Date Section content -->

</section>

</component>  
 <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.31'/>

<!-- Required if known Care Plan Section content -->

</section>

</component>

<component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1'/>

<!-- Required if known Coded Antenatal Testing and Surveillance Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4'/>

<!-- Required if known Pain Assessment Panel Section content -->

</section>

</component>  
 </strucuredBody></component>

</ClinicalDocument>

Figure 6.3.1.A.5‑1 Sample Labor and Delivery History and Physical Document

Add section 6.3.1.B

#### 6.3.1.B Labor and Delivery Summary 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2

##### The Labor and Delivery Summary (LDS) content profile represents a summary of the most critical information concerning the labor and delivery care in a birthing facility. The LDS is a Medical Summary and inherits all header constraints from Medical Summary. It also uses parts of the Labor and Delivery History and Physical profile where needed.

##### 6.3.1.B.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:pcc:lds:2009**

##### 6.3.1.B.2 LOINC Code

The LOINC code for this document is **57057-2** Labor and delivery summary

##### 6.3.1.B.3 Standards

|  |  |
| --- | --- |
| CCD | ASTM/HL7 Continuity of Care Document |
| CDAR2 | [HL7 CDA Release 2.0](http://www.hl7.org/documentcenter/private/standards/cda/r2/cda_r2_normativewebedition.zip) |
| ACOG AR | [American College of Obstetricians and Gynecologists (ACOG), Antepartum Record](http://www.acog.org" \o "http://www.acog.org) |
| LOINC | [Logical Observation Identifiers, Names and Codes](http://www.regenstrief.org/medinformatics/loinc/) |
| SNOMED | [Systemized Nomenclature for Medicine](http://www.snomed.org) |
| CDTHP | [CDA for Common Document Types History and Physical Notes (DSTU)](http://www.hl7.org/dstucomments/index.cfm) |

##### 6.3.1.B.4 Specification

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

* IHE Patient Care Coordination Volume 2: Final Text
* IHE PCC Content Modules 2010-2011 Supplement

Table 6.3.1.B.4-1 Labor and Delivery Summary Specification

| Template Name | Opt | Section Template Id | Value Set Template Id |
| --- | --- | --- | --- |
| Hospital Admission Diagnosis  This section shall indicate the reasons for admitting the mother to the birthing facility (e.g. premature labor, ruptured membrane). | R | 1.3.6.1.4.1.19376.1.5.3.1.3.3 | N/A |
| Admission Medication History | R2 | 1.3.6.1.4.1.19376.1.5.3.1.3.20 | N/A |
| Chief Complaint | R | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1 | N/A |
| Transport Mode | R | 1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2 | N/A |
| Assessment and Plan This section should contain assessment of the mother’s pregnancy status and expectations for care including proposals, goals, and order requests for her condition and the birthing process. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5 | N/A |
| Pain Assessment Panel | R | 1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4 | N/A |
| Coded Results  This section shall contain any lab draws during the delivery time interval including: Cord Blood Gas(es); Cord Blood for Type/Cross, Rh and Coomb’s Test. The Antepartum Laboratory Value Set may be used to represent the results. | R | 1.3.6.1.4.1.19376.1.5.3.1.3.28 | 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.7 |
| Coded Antenatal Testing and Surveillance | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.5.1 | 1.3.6.1.4.1.19376.1.5.3.1.1.21.3.10 |
| History of Present Illness | R | 1.3.6.1.4.1.19376.1.5.3.1.3.4 | N/A |
| History of Past Illness  This section shall include clinically relevant information to the labor and delivery. This section should use the codes as specified in the Antepartum History and Physical History of Past Illness Value Set. | R | 1.3.6.1.4.1.19376.1.5.3.1.3.8 | 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.1 |
| Problems  This section shall include the patient’s current active problem list as well as any labor, delivery and/or operative complications the patient may have including significant fever > 100.4 . | R | 1.3.6.1.4.1.19376.1.5.3.1.3.6 | N/A |
| Coded Advance Directives | R2 | 1.3.6.1.4.1.19376.1.5.3.1.3.35 | N/A |
| Birth Plan | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.1 | N/A |
| Allergies and Other Adverse Reactions  This section shall include one observation of Latex Allergy which may be negated through the negationInd attribute. Latex Allergy is particularly relevant for Obstetrics because of the frequency of vaginal exams that might involve the use of latex gloves. The observation value code for Latex Allergy is '300916003'. The codeSystem is '2.16.840.1.113883.6.96'. The codeSystemName is 'SNOMED CT' | R | 1.3.6.1.4.1.19376.1.5.3.1.3.13 | N/A |
| Coded Physical Exam  This section shall also include mother’s weight at delivery. | R | 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 | N/A |
| Estimated Delivery Date | R | 1.3.6.1.4.1.19376.1.5.3.1.1.11.2.2.1 | N/A |
| Medications Administered  This section shall include the following data elements including route, timing and indication:  Anesthesia, Sedatives,Tocolytics,Oxytocin, Antihypertensives, Anticonvulsants/Antispasmodics, Opiates (IM or IV), Antibiotics,  Other Medications | R | 1.3.6.1.4.1.19376.1.5.3.1.3.21 | N/A |
| Intravenous Fluids Administered  This section shall include the types of IV fluids the mother received. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6 | N/A |
| Intake and Output  This section shall include any intake and output while the newborn is in the delivery suite (excluding estimated blood loss) such as: first urine/void; stool; gastric output; and if breast fed in the delivery room. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3 | N/A |
| Estimated Blood Loss | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.9.2 | N/A |
| Transfusion History | R | 1.3.6.1.4.1.19376.1.5.3.1.1.9.12 | N/A |
| History of Surgical Procedures  This section shall contain any procedure that occurred during the interval between the Labor & Delivery History and Physical and the Labor & Delivery summary time frames. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2 | N/A |
| Labor and Delivery Events  This section shall contain information pertinent to the labor and delivery process including: date/time of labor onset, type of labor, duration of active phase of labor, spontaneous rupture of membranes (date/time), description of amniotic fluid (color, character, odor, amount/quantity), presence of particulate meconium, delivery obstetric provider, delivery date/time, placenta delivery date/time, weeks gestation at time of delivery, presentation of fetus at delivery and fetal monitoring findings. | R | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3 | N/A |
| Labor and Delivery Events: Procedures and Interventions  This section shall contain procedures and interventions specific to labor and delivery events. These may include induction, the delivery type (e.g. vaginal, vaginal birth after cesarean section or cesarean section along with incision type), electronic fetal monitoring, etc. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 | N/A |
| Labor and Delivery Events: Event Outcomes  This section shall include event outcomes such as live birth or stillborn and also including maternal death with date/time. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9 | N/A |
| Newborn Delivery Information  This section shall contain information pertaining to the newborns delivery including the birth date and time. This will be the same as the delivery date/time in the Labor and Delivery events section. | R | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 | N/A |
| Newborn Delivery Information: Coded Physical Exam Section  This section shall include information about the newborn such as: gender/sex of the newborn; birthweight; length; head circumference; cord vessel count; gestational age assessment; size (AGA, SGA or LGA); apgar score assessment ; vital signs, physical exam findings | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.9.15.1 | N/A |
| Newborn Delivery Information: Problems  This section shall describe problems that the newborn might have had during or immediately prior to delivery as well as delivery complications. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.3.6 | N/A |
| Newborn Delivery Information: Procedures and Interventions  This section shall include the procedures and interventions received by the newborn such as suction or resuscitation. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 | N/A |
| Newborn Delivery Information: Medications Administered  This section shall include the medication that was administered to the newborn while in the birthing suite such as: Vitamin K (Aquamephyton) injection; erythromycin eye ointment;  and resuscitation medications (if any) including date, time, and route of administration. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.3.21 | N/A |
| Newborn Delivery Information: Event Outcomes  This section shall include the outcomes of the procedures and interventions such as a resuscitation event. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9 | N/A |
| Intake and Output | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.20.2.3 | N/A |

##### 6.3.1.B.5 Conformance

CDA Release 2.0 documents that conform to the requirements of this content module shall indicate their conformance by the inclusion of the appropriate <templateId> elements in the header of the document. This is shown in the sample document below. A CDA Document may conform to more than one template. This content module inherits from the Medical Summary content module, and so must conform to the requirements of that template as well, thus all <templateId> elements shown in the example below shall be included.

<ClinicalDocument xmlns='urn:hl7-org:v3'>

<typeId extension="POCD\_HD000040" root="2.16.840.1.113883.1.3"/>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.2'/><!--Medical Summary-->  
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.1.2'/><!--Labor and Delivery Summary-->

<id root=' ' extension=' '/>

<code code='57057-2' displayName='Labor and delivery summary'

codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>

<title>Labor and Delivery Summary</title>

<effectiveTime value='20080601012005'/>

<confidentialityCode code='N' displayName='Normal'

codeSystem='2.16.840.1.113883.5.25' codeSystemName='Confidentiality' />

<languageCode code='en-US'/>

 :

<component><structuredBody>

 <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.3'/>

<!-- Required Hospital Admission Diagnosis Section content -->

</section>

</component>

 <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.20'/>

<!-- Required if known Admission Medication History Section content -->

</section>

</component>

 <component>

<section>

<templateId root='[1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1](#_1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1.htm)'/>

<!-- Required Chief Complaint Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2'/>

<!-- Required Transport Mode Section content -->

</section>

</component>

 <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.13.2.5'/>

<!-- Required if known Assessment and Plan Section content -->

</section>

</component>

 <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4'/>

<!-- Required Pain Assessment Panel Section content -->

</section>

</component>

 <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.28'/>

<!-- Required Coded Results Section content -->

</section>

</component>

 <component>

<section>

<templateId root='[1.3.6.1.4.1.19376.1.5.3.1.3.4](#_1.3.6.1.4.1.19376.1.5.3.1.3.4.htm)'/>

<!-- Required History of Present Illness Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.8'/>

<!-- Required History of Past Illness Section content -->

</section>

</component>  
  <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.6 '/>

<!-- Required Problems Section content -->

</section>

</component>

 <component>

<section>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.3.35'/>

<!-- Required if known Coded Advance Directives Section content -->

</section>

</component>

 <component>

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<!-- Required if known Birth Plan Section content -->

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<!-- Required Allergies and Other Adverse Reactions Section content -->

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<!-- Required Coded Physical Exam Section content -->

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<!-- Required Estimated Delivery Date Section content -->

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<!-- Required Medications Administered Section content -->

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<!-- Required if known Intravenous Fluids Administered Section content -->

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<!-- Required if known History of Surgical Procedures Section content -->

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<!-- Required if known Intake and Output Section content -->

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<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.9.12'/>

<!-- Required Transfusion History Section content -->

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<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.16.2.2'/>

<!-- Required if known History of Surgical Procedures Section content -->

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<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.3'/>

<!-- Required Labor and Delivery Events Section content -->

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<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4'/>

<!-- Required Newborn Delivery Information Section content -->

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</strucuredBody></component>

</ClinicalDocument>

Figure 6.3.1.B.5‑1 Sample Labor and Delivery Summary Document

Add section 6.3.1.C

#### 6.3.1.C Maternal Discharge Summary 1.3.6.1.4.1.19376.1.5.3.1.1.21.1.3

The Maternal Discharge Summary (MDS) content profile represents a snapshot of the patient’s postpartum stay until her discharge from the birthing facility. The MDS is a Medical Summary and inherits all header constraints from Medical Summary.

##### 6.3.1.C.1 Format Code

The XDSDocumentEntry format code for this content is **urn:ihe:pcc:mds:2009**

##### 6.3.1.C.2 LOINC Code

The LOINC code for this document is **57058-0** Labor and delivery summary

##### 6.3.1.C.3 Standards

|  |  |
| --- | --- |
| CCD | ASTM/HL7 Continuity of Care Document |
| CDAR2 | [HL7 CDA Release 2.0](http://www.hl7.org/documentcenter/private/standards/cda/r2/cda_r2_normativewebedition.zip) |
| ACOG AR | [American College of Obstetricians and Gynecologists (ACOG), Antepartum Record](http://www.acog.org" \o "http://www.acog.org) |
| LOINC | [Logical Observation Identifiers, Names and Codes](http://www.regenstrief.org/medinformatics/loinc/) |
| SNOMED | [Systemized Nomenclature for Medicine](http://www.snomed.org) |
| CDTHP | [CDA for Common Document Types History and Physical Notes (DSTU)](http://www.hl7.org/dstucomments/index.cfm) |

##### 6.3.1.C.4 Specification

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

* IHE Patient Care Coordination Volume 2: Final Text
* IHE PCC Content Modules 2010-2011 Supplement

Table 6.3.1.C.4-1 Maternal Discharge Summary Specification

| Template Name | Opt | Section Template Id | Value Set Template Id |
| --- | --- | --- | --- |
| Hospital Admission Diagnosis | R | 1.3.6.1.4.1.19376.1.5.3.1.3.3 | N/A |  |
| Discharge Diagnosis | R | 1.3.6.1.4.1.19376.1.5.3.1.3.7 | N/A |
| Discharge Disposition  This section shall include the discharge dispostion such as discharge to home, transfer to another facility, expired (maternal death including date/time), etc. | R | 1.3.6.1.4.1.19376.1.5.3.1.3.32 | N/A |
| Transport Mode | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2 | N/A |
| Discharge Status  This section shall include the patient’s status or condition at discharge such as stable, critical, etc. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.12 | N/A |
| Allergies and Other Adverse Reactions | R | 1.3.6.1.4.1.19376.1.5.3.1.3.13 | N/A |
| Hospital Course | R | 1.3.6.1.4.1.19376.1.5.3.1.3.5 | N/A |
| Coded Advance Directives | R2 | 1.3.6.1.4.1.19376.1.5.3.1.3.35 | N/A |
| Hospital Discharge Medications | R | 1.3.6.1.4.1.19376.1.5.3.1.3.22 | N/A |
| Coded Hospital Studies Summary | R | 1.3.6.1.4.1.19376.1.5.3.1.3.30 | N/A |
| Coded Social History  This section shall also include: Intimate Partner Violence Screening and Post-partum Depression Screening | R | 1.3.6.1.4.1.19376.1.5.3.1.3.16.1 | 1.3.6.1.4.1.19376.1.5.3.1.4.13.4 |
| Pain Assessment Panel | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.20.2.4 | N/A |
| Problems  This section shall also include any post-partum complications the patient encountered. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.3.6 | N/A |
| Braden Score | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.12.2.3 | N/A |
| Post-Partum Treatment | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.7 | N/A |
| Post-Partum Treatment: Care Plan This section shall include Contraception Plan,  Diagnostic Studies Pending,  Feeding Method and type (baby),  Follow-up Appointment date/time and follow-up provider. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.3.31 | N/A |
| Post-Partum Treatment: Procedures and Interventions  This section shall include all procedures occurring in the post-partum period including tubal ligation. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 | N/A |
| Post-Partum Treatment: Coded Results  Relevant laboratory results shall be recorded and the Antepartum Laboratory Value Set should be used to represent the results including post-partum hemoglobin and hematocrit results. | R | 1.3.6.1.4.1.19376.1.5.3.1.3.28 | 1.3.6.1.4.1.19376.1.5.3.1.1.16.5.7 |
| Post-Partum Treatment: Immunizations | R2 | 1.3.6.1.4.1.19376.1.5.3.1.4.12 | N/A |
| Post-Partum Treatment: Medications Administered | R2 | 1.3.6.1.4.1.19376.1.5.3.1.3.21 | N/A |
| Post-Partum Treatment: Discharge Diet | R2 | 1.3.6.1.4.1.19376.1.5.3.1.3.33 | N/A |
| Intravenous Fluid Administered  This section shall include the types of IV fluids administered. | R | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6 | N/A |
| Immunization Recommendations | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.18.3.1 | N/A |
| Estimated Blood Loss | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.9.2 | N/A |
| Transfusion History | R | 1.3.6.1.4.1.19376.1.5.3.1.1.9.12 | N/A |
| Patient Education | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.9.38 | N/A |
| Labor and Delivery Events: Procedures and Interventions  This section shall include information about the delivery type (e.g. vaginal, vaginal birth after cesarean section or cesarean section along with incision type, | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9 | N/A |
| Provider Orders  This section shall include information about the patient’s discharge activity. | R | 1.3.6.1.4.1.19376.1.5.3.1.1.20.2.1 | N/A |
| Consultations  This section shall include consultations such as a lactation consultation. | R2 | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.8 | N/A |
| NDS Header Module  This section shall include the first and last name of the baby at birth, at discharge and the baby’s unique identifier. | R | ? |  |
| LDS: Newborn Delivery Information  This section shall include information such as the birth date and time; birthweight; head circumference; sex/gender of newborn, etc. | R | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.4 | N/A |
| NDS Procedures and Interventions: This section shall include procedures such as a circumcision (if male). | R | 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.11 | N/A |
| NDS: Care Plan  This section shall contain information regarding the plans for the newborn including feeding plan; pediatrician’s name, etc. | R | 1.3.6.1.4.1.19376.1.5.3.1.3.31 | N/A |
| Newborn Status at Maternal Discharge | R | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.8 | N/A |
| Event Outcomes  This section shall include a narrative description of the outcomes following a procedure, an intervention or a problem during the post-partum period of the hospitalization. | R | 1.3.6.1.4.1.19376.1.5.3.1.1.21.2.9 | N/A |

##### 6.3.1.C.5 Conformance

CDA Release 2.0 documents that conform to the requirements of this content module shall indicate their conformance by the inclusion of the appropriate <templateId> elements in the header of the document. This is shown in the sample document below. A CDA Document may conform to more than one template. This content module inherits from the Medical Summary content module, and so must conform to the requirements of that template as well, thus all <templateId> elements shown in the example below shall be included.

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<typeId extension="POCD\_HD000040" root="2.16.840.1.113883.1.3"/>

<templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.2'/> <!--Medical Summary-->  
  <templateId root='1.3.6.1.4.1.19376.1.5.3.1.1.21.1.3'/> <!--Maternal Discharge Summary-->

<id root=' ' extension=' '/>

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codeSystem='2.16.840.1.113883.6.1' codeSystemName='LOINC'/>

<title>Maternal Discharge Summary</title>

<effectiveTime value='20080601012005'/>

<confidentialityCode code='N' displayName='Normal'

codeSystem='2.16.840.1.113883.5.25' codeSystemName='Confidentiality' />

<languageCode code='en-US'/>

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<!-- Required Discharge Diagnosis Section content -->

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<!-- Required Discharge Disposition Section content -->

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<!-- Required if known Transport Mode Section content -->

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<!-- Required if known Discharge Status Section content -->

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<!-- Required Allergies and Other Adverse Reactions Section content -->

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<!-- Required Hospital Course Section content -->

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<!-- Required if known Coded Advance Directives Section content -->

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<!-- Required Hospital Discharge Medications Section content -->

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<!-- Required Coded Social History Section content -->

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<!-- Required if known Post-partum Treatment Section content -->

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<!-- Required if known Immunization Recommendations Section content -->

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<!-- Required Transfusion History Section content -->

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<!-- Required Labor and Delivery Events Section content -->

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<!-- Required if known Consultations Section content -->

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<!-- Required Newborn Delivery Information Section content -->

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<!-- Required Procedures and Interventions Section content -->

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<!-- Required Care Plan Section content -->

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<!-- Required Newborn Status at Maternal Discharge Section content -->

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<!-- Required Event Outcomes Section content -->

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</ClinicalDocument>

Figure 6.3.1.C.5‑1 Sample Maternal Discharge Summary Document

1. The first three documents can be located on the IHE Website at <http://www.ihe.net/Technical_Framework/index.cfm#IT>. The remaining documents can be obtained from their respective publishers. [↑](#footnote-ref-1)