Figure 18: Care Teams Section Example

```
<section>
    <templateId root="2.16.840.1.113883.10.20.22.2.500" extension="2019-07-01"/>
    <templateId root="2.16.840.1.113883.10.20.22.2.500" extension="2022-06-01"/>
    <code code="85847-2" codeSystem="2.16.840.1.113883.6.1"/>
    <title>Patient Care Teams</title>
    <text>
        <list>
            <item>
                <content ID= "CareTeamName1">Inpatient Diabetes Care Team</content> (
                <content>Active</content>) (10/08/2018 - )

                <table>
                    <thead>
                        <tr>
                            <th>Member</th>
                            <th>Role on Team</th>
                            <th>Status</th>
                            <th>Date</th>
                        </tr>
                    </thead>
                    <tbody>
                        <tr>
                            <td>Dr. Henry Seven </td>
                            <td ID="CT1_M01">PCP</td>
                            <td>(Active)</td>
                            <td>10/18/2019</td>
                        </tr>
                    </tbody>
                </table>
            </item>
        </list>
    </text>
    <entry>
        <!--Care Team Organizer-->
... entry info here, if coded data available for care team members...

    </entry>
</section>
```

2.2 Notes Section

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.65:2016-11-01 (open)]

Table 23: Notes Section Contexts

Contained By:	Contains:
	Note Activity (required)

The Notes Section allow for inclusion of clinical documentation which does not fit precisely within any other C-CDA section. Multiple Notes sections may be included in a document provided they each

include different types of note content as indicated by a different section.code.
The Notes Section SHOULD NOT be used in place of a more specific C-CDA section. For example, notes about procedure should be placed within the Procedures Section, not a Notes Section.
When a Notes Section is present, Note Activity entries contain structured information about the note information allowing it to be more machine processable.

Table 24: Notes Section Constraints Overview

XPath	Card.	Verb	Data Type	CONF#	Value
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.65:2016-11-01)					
templateId	1..1	SHALL		3250-16935	
@root	1..1	SHALL		3250-16936	2.16.840.1.113883.10.20.22.2.65
@extension	1..1	SHALL		3250-16938	2016-11-01
code	1..1	SHALL		3250-16892	urn:oid:2.16.840.1.113883.11.20.9.68 (Note Types)
title	1..1	SHALL		3250-16891	
text	1..1	SHALL		3250-16894	
entry	1..*	SHALL		3250-16904	
act	1..1	SHALL		3250-16905	Note Activity (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.202:2016-11-01

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:3250-16935) such that it
    a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.65" (CONF:3250-16936).
    b. **SHALL** contain exactly one [1..1] **@extension**="2016-11-01" (CONF:3250-16938).
2. **SHALL** contain exactly one [1..1] **code**, which **SHOULD** be selected from ValueSet **Note Types** urn:oid:2.16.840.1.113883.11.20.9.68 **DYNAMIC** (CONF:3250-16892).

This title should reflect the kind of notes included in this section, corresponding to the code.

3. **SHALL** contain exactly one [1..1] **title** (CONF:3250-16891).

The narrative SHOULD contain human-readable representations using standard CDA narrative markup of each note to ensure widest compatibility with receivers. While allowed by CDA, the use of <renderMultiMedia> elements, which contain a referencedObject attribute pointing to an <observationMedia> or <regionOfInterest> element in the discrete entries, is discouraged in Note Sections because rendering support for these elements is not widespread.

4. **SHALL** contain exactly one [1..1] **text** (CONF:3250-16894).

If section/@nullFlavor is not present:

5. **SHALL** contain at least one [1..*] **entry** (CONF:3250-16904) such that it

a. **SHALL** contain exactly one [1..1] **Note Activity** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.202:2016-11-01) (CONF:3250-16905).

Table 25: Note Types

Value Set: Note Types urn:oid:2.16.840.1.113883.11.20.9.68

(Clinical Focus: Types of clinical notes that may exist in an EHR as narrative text, and may not have associated structured data, but are relevant and need to be included in the interoperable documentation as narrative notes. Although the content of the note is not coded, the type of note is known. The note type code is used to encode the type of note being exchanged.),(Data Element Scope: Section or entry.),(Inclusion Criteria: LOINC codes where class=DOC.ONTOLOGY.),(Exclusion Criteria: CHARINDEX('CONSENT',LNC.COMPONENT) = 0
OR CHARINDEX('Advance directives',LNC.COMPONENT) = 0 OR CHARINDEX('Agreement',LNC.COMPONENT) = 0
OR CHARINDEX('ALERT',LNC.COMPONENT) = 0
OR CHARINDEX('REPORT',LNC.COMPONENT) = 0
OR CHARINDEX('certificate',LNC.COMPONENT) = 0
OR CHARINDEX('Flowsheet',LNC.COMPONENT) = 0
OR CHARINDEX('SIGNOUT NOTE',LNC.COMPONENT) = 0
OR CHARINDEX('DIAGRAM',LNC.COMPONENT) = 0
OR CHARINDEX('Do not resuscitate',LNC.COMPONENT) = 0
OR CHARINDEX('LICENSE',LNC.COMPONENT) = 0
OR CHARINDEX('Form',LNC.COMPONENT) = 0
OR CHARINDEX('Letter',LNC.COMPONENT) = 0
OR CHARINDEX('document',LNC.COMPONENT) = 0
OR CHARINDEX('Living will',LNC.COMPONENT) = 0
OR CHARINDEX('Power of attorney',LNC.COMPONENT) = 0
OR CHARINDEX('Prescription',LNC.COMPONENT) = 0
OR CHARINDEX('VA C&P',LNC.COMPONENT) = 0
OR CHARINDEX('product list',LNC.COMPONENT) = 0
OR CHARINDEX('IMAGE',LNC.COMPONENT) = 0
OR CHARINDEX('ORDER',LNC.COMPONENT) = 0
OR CHARINDEX('CARD',LNC.COMPONENT) = 0)

This value set was imported on 11/22/2022 with a version of Latest.

Value Set Source:
https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.68/expansion

Code	Code System	Code System OID	Print Name
100018-1	LOINC	urn:oid:2.16.840.1.113883.6.1	Hospice care Note
11488-4	LOINC	urn:oid:2.16.840.1.113883.6.1	Consult note
11490-0	LOINC	urn:oid:2.16.840.1.113883.6.1	Physician Discharge summary
11492-6	LOINC	urn:oid:2.16.840.1.113883.6.1	Provider-unspecifed, History and physical note
11502-2	LOINC	urn:oid:2.16.840.1.113883.6.1	Laboratory report
11504-8	LOINC	urn:oid:2.16.840.1.113883.6.1	Surgical operation note
11505-5	LOINC	urn:oid:2.16.840.1.113883.6.1	Physician procedure note
11506-3	LOINC	urn:oid:2.16.840.1.113883.6.1	Progress note
11507-1	LOINC	urn:oid:2.16.840.1.113883.6.1	Occupational therapy Progress note
11508-9	LOINC	urn:oid:2.16.840.1.113883.6.1	Physical therapy Progress note
…			

Figure 19: Note Section Example

```
<section>
    <!-- Notes Section -->
    <templateId root="2.16.840.1.113883.10.20.22.2.65" extension="2016-11-01"/>
    <code code="11488-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Consultation note"/>
    <title>Consultation Notes</title>
    <text>
        <list>
            <item ID="ConsultNote1">
                <paragraph>Dr. Specialist - September 8, 2016</paragraph>
                <paragraph>Evaluated patient due to symptoms of...</paragraph>
            </item>
        </list>
    </text>
    <!-- Note Activity entry -->
    <entry>
        <act classCode="ACT" moodCode="EVN">
            <templateId root="2.16.840.1.113883.10.20.22.4.202" extension="2016-11-01"/>
            <code code="34109-9" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
displayName="Note">
                <!-- Code must match or be equivalent to section code -->
                <translation code="11488-4" codeSystem="2.16.840.1.113883.6.1"
codeSystemName="LOINC" displayName="Consultation note" />
            </code>
            <text>
                <reference value="#ConsultNote1" />
            </text>
            <statusCode code="completed"/>
            <!-- Clinically-relevant time of the note -->
            <effectiveTime value="20160908" />
            <!--...-->
        </act>
    </entry>
</section>
```


3 ENTRY

3.1 Assessment Scale Observation (V2)

[observation: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.4.69:2022-06-01 (open)]

Table 26: Assessment Scale Observation (V2) Contexts

Contained By:	Contains:
Disability Status Observation (optional)	

An assessment scale is a collection of observations that together can yield a calculated or non-calculated summary evaluation of a one or more conditions. Examples include the Braden Scale (assesses pressure ulcer risk), APACHE Score (estimates mortality in critically ill patients), Mini-Mental Status Exam (assesses cognitive function), APGAR Score (assesses the health of a newborn), Glasgow Coma Scale (assesses coma and impaired consciousness), and WE CARE (Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education - a clinic-based screening and referral system developed for pediatric settings).

When an Assessment Scale Observation is contained in a Problem Observation, a Social History Observation or a Procedure instance that is Social Determinant of Health focused, that Assessment scale **MAY** contain assessment scale observations that represent question and answer pairs from SDOH screening instruments that are represented in LOINC. Note that guidance on the use of LOINC in assessment scales already exists in Assessment Scale Observation constraints and Assessment Scale Supporting Observations constraints.