

HITSP Plan of Care Component

HITSP/C162



Healthcare Information Technology Standards Panel

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1.0 INTRODUCTION

1.1 OVERVIEW

This specification describes the ongoing plan of care for a patient. It is intended to describe the current plan of care for the patient from the Nursing perspective during transfers of care.

1.2 COPYRIGHT PERMISSIONS

COPYRIGHT NOTICE

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IHE materials used in this document have been extracted from relevant copyrighted materials with permission of Integrating the Healthcare Enterprise (IHE) International. Copies of this standard may be retrieved from the [IHE Web Site](#).

1.3 REFERENCE DOCUMENTS

A list of key reference documents and background material is provided in the table below. HITSP-maintained reference documents can be retrieved from the [HITSP](#) web Site.

Table 1-1 Reference Documents

| Reference Document | Document Description |
|---|--|
| HITSP Acronyms List | Lists and defines the acronyms used in this document |
| HITSP Glossary | Provides definitions for relevant terms used by HITSP documents |
| TN900 - Security and Privacy | TN900 is a reference document that provides the overall context for use of the HITSP Security and Privacy constructs |
| TN901 - Clinical Documents | TN901 is a reference document to provide the overall context for use of the HITSP Care Management and Health Records constructs |
| TN903 – Data Architecture | TN903 is a reference document that provides the overall context for use of the HITSP Data Architecture constructs |
| TN904 – Harmonization Framework and Exchange Architecture | TN904 is a reference document that provides the overall context for use of the HITSP Harmonization Framework and Exchange Architecture |

1.4 CONFORMANCE

This section describes the conformance criteria, which are objective statements of requirements that can be used to determine if a specific behavior, function, interface, or code set has been implemented correctly.

1.4.1 CONFORMANCE CRITERIA

In order to claim conformance to this construct specification, an implementation must satisfy all the requirements and mandatory statements listed in this specification, the associated HITSP Interoperability Specification or Capability, its associated construct specifications, as well as conformance criteria from the selected base and composite standards. A conformant system must also implement all of the required interfaces within the scope, subset or implementation option that is selected from the associated Interoperability Specification.



Claims of conformance may only be made for the overall HITSP Interoperability Specification or Capability with which this construct is associated.

1.4.2 CONFORMANCE SCOPING, SUBSETTING AND OPTIONS

A HITSP Interoperability Specification or Capability must be implemented in its entirety for an implementation to claim conformance to the specification. HITSP may define the permissibility for interface scoping, subsetting or implementation options by which the specification may be implemented in a limited manner. Such scoping, subsetting and options may extend to associated constructs, such as this construct. This construct must implement all requirements within the selected scope, subset or options as defined in the associated Interoperability Specification or Capability to claim conformance.



2.0 COMPONENT DEFINITION

A Component defines HITSP atomic constructs used to support an information exchange or to meet an infrastructure requirement. This is accomplished by:

- (a) Referencing one or more underlying standards
- (b) Specifying constraints and other rules for using the standards

2.1 CONTEXT OVERVIEW

The Patient Plan of Care is an individualized, mutually agreed upon plan. The plan includes problem issues (nursing diagnoses), expected healthcare outcomes, implementable interventions, and evaluation of progress toward outcomes based on follow-up assessments. It is a framework to document critical thinking necessary for excellent evidenced-based outcomes.

2.1.1 COMPONENT DEPENDENCIES

Table 2-1 Component Dependencies

| Standard/HITSP Component | Depends On (Name of standard/HITSP Component that it depends on) | Dependency Type (Pre-condition, Post-condition, General) | Purpose (Reason for this dependency) |
|---------------------------|---|--|---|
| HITSP/C162 - Plan of Care | HITSP/C83 - CDA Content Modules | General | Identifies the content modules and sections constrained by this Component |

2.2 RULES FOR IMPLEMENTING

2.2.1 DATA MAPPING

The Patient Plan of Care is an individualized, mutually agreed upon plan. Table 2-2 defines the HITSP constraints for a plan of care. In no case are the HITSP constraints below less strict than those defined by IHE.

The template identifier for this 2.16.840.1.113883.3.88.11.162.1

- C162-[CT1-1] Implementations of this component **SHALL** support the Integrating the Healthcare Enterprise (IHE) Patient Care Coordination (PCC) Technical Framework Supplement Patient Plan of Care, Trial Implementation, October 8, 2009
- C162-[CT1-2] A CDA Document **SHALL** declare conformance to this HITSP document, by including a <templateId> element containing the following value:
2.16.840.1.113883.3.88.11.162.1
- C163-[CT1-3] The CDA document **SHALL** declare conformance to the IHE Plan of Care document by including a <templateId> containing the following value:
1.3.6.1.4.1.19376.1.5.3.1.1.20.1.1

Table 2-2 Plan of Care Content Modules

| Constraint ID | Content Module | HITSP Optional Entry | HITSP Repeatable Entry | Specification Reference |
|---------------|----------------|----------------------------|------------------------------|--|
| C162-[CT2—1] | Assessments | R | N | See HITSP/C83 Section 2.2.1.44 Assessments |



| Constraint ID | Content Module | HITSP Optional Entry | HITSP Repeatable Entry | Specification Reference |
|---------------|---------------------------------------|----------------------------|------------------------------|---|
| C162-[CT2—2] | Physical Examination | C | N | See HITSP/C83 Section 2.2.1.18 Physical Examination. SHALL be present when a physical examination is performed during the assessment of the patient |
| C162-[CT2—3] | Review of Systems | C | N | See HITSP/C83 Section 2.2.1.20 Review of Systems. SHALL be present when a review of systems is performed during the assessment of the patient |
| C162-[CT2—4] | Functional Status | O | N | See HITSP/C83 Section 2.2.1.9 Functional Status SHOULD be present when any assessments of functional status are performed on the patient |
| C162-[CT2—5] | Family History | O | N | See HITSP/C83 Section 2.2.1.25 Family History SHOULD be present when there is relevant family history |
| C162-[CT2—6] | Social History | O | N | See HITSP/C83 Section 2.2.1.26 Social History SHOULD be present when there is relevant social history |
| C162-[CT2—7] | Active Problems | R | N | See HITSP/C83 Section 2.2.1.3 Problem List |
| C162-[CT2—8] | Allergies and Other Adverse Reactions | R | N | See HITSP/C83 Section 2.2.1.2 Allergies and Other Adverse Reactions |
| C162-[CT2—9] | Treatment Plan | R | N | See HITSP/C83 Section 2.2.1.24 Plan of Care |
| C162-[CT2—10] | Provider Orders | R | N | See HITSP/C83 Section 2.2.1.46 Provider Orders |
| C162-[CT2—11] | Advance Directives | R | N | See HITSP/C83 Section 2.2.1.16 Advance Directives |
| C162-[CT2—12] | Procedures and Interventions | C | N | See HITSP/C83 Section 2.2.1.45 Procedures SHALL be present when procedures and interventions have been performed |
| C162-[CT2—13] | Medications Administered | C | N | See HITSP/C83 Section 2.2.1.15 Medications Administered SHALL be present when medications have been administered |
| C162-[CT2—14] | Fluids Administered | C | N | See IHE templateID 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6 SHALL be present when fluids have been administered. |



| Constraint ID | Content Module | HITSP Optional Entry | HITSP Repeatable Entry | Specification Reference |
|---------------|----------------------------|----------------------|------------------------|--|
| C162-[CT2—15] | History of Present Illness | C | N | See HITSP/C83 Section 2.2.1.7 History of Present Illness SHALL be present when there is relevant history of past illness |
| C162-[CT2—16] | Coded List of Surgeries | C | N | See HITSP/C83 Section 2.2.1.8 List of Surgeries SHALL be present when there is relevant surgical history |
| C162-[CT2—17] | Immunizations | C | N | See HITSP/C83 Section 2.2.1.17 Immunizations SHALL be present to record relevant immunization status when immunization status exists |
| C162-[CT2—18] | Person Information | R | N | See HITSP/C83 Section 2.2.2.1 Personal Information |

Optionality = “R” for Required, “R2” for Required if Known or “O” for Optional, or “C” for Conditional. Repeatable = “Y” for Yes, “N” for No

2.3 STANDARDS

2.3.1 REGULATORY GUIDANCE

Table 2-3 Regulatory Guidance

| Regulation | Description |
|-----------------------------------|-------------|
| No applicable regulatory guidance | |

2.3.2 SELECTED STANDARDS

Table 2-4 Selected Standards

| Standard | Description |
|---|--|
| Integrating the Healthcare Enterprise (IHE) Patient Care Coordination (PCC) Technical Framework Supplement Patient Plan of Care, Trial Implementation, October 10, 2009 | The IHE Patient Care Coordination Technical Framework (PCC TF) defines specific implementations (called Integration Profiles) of established standards to deal with integration issues that cross providers, patient problems or time. The Patient Plan of Care is an individualized, mutually agreed upon plan. The plan includes problem issues (nursing diagnoses), expected healthcare outcomes, implementable interventions, and evaluation of progress toward outcomes based on follow-up assessments. For more information visit www.ihe.net |
| Health Level Seven (HL7) HL7 Version 3 Standard: Clinical Document Architecture (CDA), Release 2 | The HL7 Clinical Document Architecture is an XML-based document markup standard that specifies the structure and semantics of clinical documents for the purpose of exchange. CDA is one instantiation of HL7's Version 3.0 Reference Information Model (RIM) into a specific message format. Of particular focus for HITSP Interoperability Specifications are message formats for Laboratory Results and Continuity of Care (CCD) documents. Release 2 of the HL7 Clinical Document Architecture (CDA) is an extension to the original CDA document markup standard that specifies the structure and semantics of clinical documents for the purpose of exchange. CDA R2 includes a prose document in HTML, XML schemas, data dictionary, and sample CDA documents. CDA R2 further builds upon other HL7 standards beyond just the Version 3.0 Reference Information Model (RIM) and incorporates Version 3.0 Data Structures, Vocabulary, and the XML Implementation Technology Specifications for Data Types and Structures. For more information visit www.hl7.org |



| Standard | Description |
|--|---|
| Health Level Seven (HL7) Implementation Guide: CDA Release 2.0 – Continuity of Care Document (CCD), April 01, 2007 | The Continuity of Care Document Implementation Guide describes constraints on the HL7 Clinical Document Architecture, Release 2 (CDA) specification in accordance with requirements set forward in ASTM International E2369-05 Standard Specification for Continuity of Care Record (CCR). The resulting specification, known as the Continuity of Care Document (CCD), is developed as a collaborative effort between ASTM International and HL7. It is intended as an alternate implementation to the one specified in ASTM International ADJE2369 for those institutions or organizations committed to implementation of the HL7 Clinical Document Architecture. For more information visit www.hl7.org |

2.3.3 INFORMATIVE REFERENCE STANDARDS

Table 2-5 Informative Reference Standards

| Standard | Reason for Use |
|-------------------------------|---|
| ANA Nursing Standards Package | ANA Standards are essential references for all practicing nurses, nursing students and faculty, other health care providers and researchers, and professionals in health care funding, legal, policymaking, and regulatory work. This set of over 1,000 pages contains the newly revised keystone of the set, Nursing: Scope and Standards of Practice, plus one each of the current standards in 21 nursing specialties. For more information visit www.nursingworld.org |



3.0 APPENDIX

No additional information at this time.



4.0 DOCUMENT UPDATES

The following sections provide the details of updates made to this document.

4.1 JANUARY 31, 2010

No changes. This is the first published version of the document.

