

# HITSP Operative Note Document Component

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HITSP/C166



Healthcare Information Technology Standards Panel

*Submitted to:*

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*Submitted by:*

**Care Management and Health Records Domain Technical Committee**



## DOCUMENT CHANGE HISTORY

Version Number	Description of Change	Name of Author	Date Published
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## 1.0 INTRODUCTION

### 1.1 OVERVIEW

The Operative Note or Report is created following a surgical or other high-risk procedure and records the pre- and post-surgical diagnosis, pertinent events of the procedure, as well as the condition of the patient following the procedure. The report should be sufficiently detailed to support the diagnoses, justify the treatment, document the course of the procedure, and provide continuity of care. The Operative Note is a frequently used type of procedure note with specific requirements set forth by regulatory agencies.

### 1.2 COPYRIGHT PERMISSIONS

#### COPYRIGHT NOTICE

© 2010 ANSI. This material may be copied without permission from ANSI only if and to the extent that the text is not altered in any fashion and ANSI's copyright is clearly noted.

### 1.3 REFERENCE DOCUMENTS

This section provides a list of key reference documents and background material.

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
<a href="#">HITSP Acronyms List</a>	Lists and defines the acronyms used in this document
<a href="#">HITSP Glossary</a>	Provides definitions for relevant terms used by HITSP documents
<a href="#">TN900 - Security and Privacy</a>	TN900 is a reference document that provides the overall context for use of the HITSP Security and Privacy constructs
<a href="#">TN901 - Clinical Documents</a>	TN901 is a reference document that provides the overall context for use of the HITSP Care Management and Health Records constructs
<a href="#">TN903 - Data Architecture</a>	TN903 is a reference document that provides the overall context for use of the HITSP Data Architecture constructs

### 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

### 2.1 CONTEXT OVERVIEW

The Operative Note or Report is created immediately following a surgical or other high-risk procedure and records the pre- and post-surgical diagnosis, pertinent events of the procedure, as well as the condition of the patient following the procedure. The report should be sufficiently detailed to support the diagnoses, justify the treatment, document the course of the procedure, and provide continuity of care.

#### 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/C166 – Operative Note Document	HITSP/C83 – CDA Content Modules	General	Identifies the data in the workflow elements used by this Component

### 2.2 RULES FOR IMPLEMENTING

#### 2.2.1 DATA MAPPING

The template identifier for this document is 2.16.840.1.113883.3.88.11.166.1.

C166-[CT1-1] Implementations of this component **SHALL** support the HL7 Implementation Guide for CDA Release 2: Operative Notes DSTU Release 1.

C166-[CT1-2] An Operative Notes Document **SHALL** declare conformance to this specification by including a **<templateId>** element with the root attribute set to the value 2.16.840.1.113883.3.88.11.166.1

C166-[CT1-3] The CDA document **SHALL** include the following templateId in the header of the document **<templateId root="2.16.840.1.113883.10.20.3**

C166-[CT1-4] The CDA document **SHALL** declare conformance to the HL7 Operative Note document, by including a ClinicalDocument/**<templateId> element** containing the value 2.16.840.1.113883.10.20.7

Table 2-2 Data Mapping - Operative Note Content Modules

Constraint ID	Content Module	HITSP Optional Entry	HITSP Repeatable Entry	Specification Reference
C166-[CT2-1]	Preoperative Diagnosis	R	N	See HITSP/C83 Section 2.2.1.29 Preoperative Diagnosis
C166-[CT2-2]	Postoperative Diagnosis	R	N	See HITSP/C83 Section 2.2.1.30 Postoperative Diagnosis
C166-[CT2-3]	Surgery Description	R	N	See HITSP/C83 Section 2.2.1.31 Surgery Description
C166-[CT2-4]	Surgical Operation Note Findings	R	N	See HITSP/C83 Section 2.2.1.32 Surgical Operation Note Findings
C166-[CT2-5]	Anesthesia	R	N	See HITSP/C83 Section 2.2.1.33 Anesthesia
C166-[CT2-6]	Estimated Blood Loss	R	N	See HITSP/C83 Section 2.2.1.34 Estimated Blood Loss
C166-[CT2-7]	Complications	R	N	See HITSP/C83 Section 2.2.1.36 Complications



Constraint ID	Content Module	HITSP Optional Entry	HITSP Repeatable Entry	Specification Reference
C166-[CT2-8]	Specimens Removed	R	N	See HITSP/C83 Section 2.2.1.35 Specimens Removed
C166-[CT2-9]	Planned Procedure	O	N	See HITSP/C83 Section 2.2.1.37 Planned Procedure
C166-[CT2-10]	Indications	O	N	See HITSP/C83 Section 2.2.1.38 Indications
C166-[CT2-11]	Disposition	O	N	See HITSP/C83 Section 2.2.1.39 Disposition
C166-[CT2-12]	Plan	O	N	See HITSP/C83 Section 2.1.2.21 Plan of Care
C166-[CT2-13]	Operative Note Fluids	O	N	See HITSP/C83 Section 2.1.2.40 Operative Note Fluids
C166-[CT2-14]	Operative Note Surgical Procedure	O	N	See HITSP/C83 Section 2.2.1.41 Operative Note Surgical Procedure
C166-[CT2-15]	Surgical Drains	O	N	See HITSP/C83 Section 2.1.2.42 Surgical Drains
C166-[CT2-16]	Implants	O	N	See HITSP/C83 Section 2.1.2.43 Implants
C166-[CT2-17]	Assessments	O	N	See HITSP/C83 Section 2.1.2.44 Assessments

Optionality Legend: "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
HL7 Implementation Guide for CDA Release 2.0 Operative Note DSTU Release 1	The Operative Note or Report is created immediately following a surgical or other high-risk procedure and records the pre- and post-surgical diagnosis, pertinent events of the procedure, as well as the condition of the patient following the procedure. The report should be sufficiently detailed to support the diagnoses, justify the treatment, document the course of the procedure, and provide continuity of care. For more information visit <a href="http://www.hl7.org">www.hl7.org</a>



Standard	Description
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 <a href="http://www.hl7.org">www.hl7.org</a>

### 2.3.3 INFORMATIVE REFERENCE STANDARDS

**Table 2-5 Informative Reference Standards**

Standard	Reason for Use
No applicable informative reference standards	



### 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.

