

# HITSP Emergency Care Summary Document Using IHE Emergency Department Encounter Summary (EDES) Component

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HITSP/C28



Healthcare Information Technology Standards Panel

*Submitted to:*

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*Submitted by:*

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



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## 1.0 INTRODUCTION

### 1.1 OVERVIEW

An Emergency Department (ED) summary document is the collection of data from multiple sources (such as physicians, nurses, technologists, etc.) recording the assessments and care delivered by the ED team in response to an ED visit. It is a summary of the patient's current health status and the care delivered in the ED between arrival and departure. It is not the complete "ED Chart" that may be the legal document of care, but a collection of medical summaries

### 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
<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

This Component is based upon the output developed by the Integrating the Healthcare Enterprise Patient Care Coordination Committee (IHE PCC). This Component specifies the use of the Emergency Department Encounter Summary (EDES), Technical Framework Trial Implementation Supplement August 10, 2009.

As stated in IHE PCC-Technical Framework Supplement:

*The text for the PCC-TF specification begins here:*

The ED Encounter Summary is a folder in XDS that defines a collection of documents. Separate content profiles must be created for the various kinds of documents that might be included to represent the various kinds of documents that might be found in the EDES Folder. These content profiles include:

- ED Triage Note – this document contains data compiled during the ED triage process
- ED Nursing Note – this document contains data compiled during the on-going care (after initial triage) of the ED patient
- Composite ED Triage and ED Nursing Note – this document can be used in lieu of individual triage and ED Nursing notes by implementers where both above documents may be consolidated into a single document
- ED Physician Note – this document is a summary view of ED physician documentation
- Pre-hospital Care Report – this document has been identified as a future work product and is on the PCC Roadmap EDR (Emergency Department Referral) – this document was developed in the 2006 IHE cycle to support referral of a patient to the emergency department
- Diagnostic Imaging Reports – shall be shared using XDS-I
- Lab Reports – Laboratory reports shall be shared using XD\*-LAB
- Consultations – future document type specification
- Transfer Summary – future document type specification
- Summary of Death – future document type specification

*The text for the PCC-TF specification ends here.*

IHE has not defined all of the content profiles in the above list. This Component specifies the support for the ED Triage Note, ED Nursing Note and ED Physician Note.

#### 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/C28 – Emergency Care Summary Document using IHE Emergency Department Encounter Summary (EDES)	HITSP/C83 – CDA Content Modules	General	Defines the content modules



## 2.2 RULES FOR IMPLEMENTING

### 2.2.1 DATA MAPPING

- C28-[CT1-1] Implementations of this component SHALL support the Integrating the Healthcare Enterprise (IHE) Patient Care Coordination (PCC), Emergency Department Encounter Summary (EDES), Technical Framework Supplement Trial Implementation August 10, 2009 Profile or later.
- C28-[CT1-2] A CDA Document SHALL declare conformance to this specification by including a <templated> element with the root attribute set to the value of (ED Triage Note) 2.16.840.1.113883.3.88.11.28.1, (ED Nursing Note) 2.16.840.1.113883.3.88.11.28.2, (ED Composite Triage and Nursing Note) 2.16.840.1.113883.3.88.11.28.3 or (ED Physician Note) 2.16.840.1.113883.3.88.11.28.4.
- C28-[CT1-3] The CDA document SHALL declare conformance to one of the IHE documents, by including a <templated> containing one of the following values: (ED Triage Note) 1.3.6.1.4.1.19376.1.5.3.1.1.13.1.1, (ED Nursing Note) 1.3.6.1.4.1.19376.1.5.3.1.1.13.1.2, (ED Composite Triage and Nursing Note) 1.3.6.1.4.1.19376.1.5.3.1.1.13.1.3 or (ED Physician Note) 1.3.6.1.4.1.19376.1.5.3.1.1.13.1.4.

#### 2.2.1.1 ED TRIAGE NOTE

The following table defines the HITSP constraint for a Triage Note, which contains the data compiled during the Emergency Department triage process.

The template identifier for this module is 2.16.840.1.113883.3.88.11.28.1

**Table 2-2 Data Mapping - ED Triage Note Content Modules**

Constraint ID	Content Module	HITSP Optional Entry	HITSP Repeatable Entry	Specification Reference
C28-[CT2—1]	Acuity Assessment	R	N	See IHE templated 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.2
C28-[CT2—2]	Allergies	R	N	See HITSP/C83 Section 2.2.1.2 Allergy and Other Adverse Reactions
C28-[CT2—3]	Assessments	R2	N	See HITSP/C83 Section 2.2.1.44 Assessments
C28-[CT2—4]	Chief Complaint	R	N	See HITSP/C83 Section 2.2.1.5 Chief Complaint
C28-[CT2—5]	Current Meds	R	N	See HITSP/C83 Section 2.2.1.12 Medications
C28-[CT2—6]	Family History	R2	N	See HITSP/C83 Section 2.2.1.25 Family History
C28-[CT2—7]	History of Past Illness	R2	N	See HITSP/C83 Section 2.2.1.4 History of Past Illness
C28-[CT2—8]	History of Pregnancies	R2	N	See IHE templated 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4
C28-[CT2—9]	History of Present Illness	R	N	See HITSP/C83 Section 2.2.1.7 History of Present Illness
C28-[CT2—10]	Immunizations	R2	N	See HITSP/C83 Section 2.2.1.17 Immunizations
C28-[CT2—11]	Intravenous Fluids Administered	R2	N	See IHE templated 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6
C28-[CT2—12]	List of Surgeries	R2	N	See HITSP/C83 Section 2.2.1.8 List of Surgeries
C28-[CT2—13]	Medications Administered	R2	N	See HITSP/C83 Section 2.2.1.15 Medications Administered
C28-[CT2—14]	Mode of Arrival	R	N	See IHE templated 1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2
C28-[CT2—15]	Patient Administrative Identifiers	R	N	See HITSP/C83 Section 2.2.2.1 Person Information
C28-[CT2—16]	Person Information	R	N	See HITSP/C83 Section 2.2.2.1 Person Information
C28-[CT2—17]	Procedures and Interventions	R2	N	See HITSP/C83 Section 2.2.1.45 Procedures and Interventions
C28-[CT2—18]	Reason for Visit	R	N	See IHE templated 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1.1
C28-[CT2—19]	Social History	R2	N	See HITSP/C83 Section 2.2.1.26 Social History
C28-[CT2—20]	Vital Signs	R2	N	See HITSP/C83 Section 2.2.1.19 Vital Signs

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.





### 2.2.1.2 ED NURSING NOTE

The following table defines the HITSP constraint for a Nursing Note, which contains the data compiled during the ongoing care (after initial triage) of the Emergency Department patient.

The template identifier for this module is 2.16.840.1.113883.3.88.11.28.2

**Table 2-3 Data Mapping - ED Nursing Note Content Modules**

Constraint ID	Content Module	HITSP Optional Entry	HITSP Repeatable Entry	Specification Reference
C28-[CT3—1]	Assessments	R	N	See HITSP/C83 Section 2.2.1.44 Assessments
C28-[CT3—2]	ED Disposition	R	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.10
C28-[CT3—3]	Functional Status Assessments	O	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1
C28-[CT3—4]	Intravenous Fluids Administered	R	N	templateId 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6
C28-[CT3—5]	Medications Administered	R	N	See HITSP/C83 Section 2.2.1.15 Medications Administered
C28-[CT3—6]	Patient Administrative Identifiers	R	N	See HITSP/C83 Section 2.2.2.1 Person Information
C28-[CT3—7]	Person Information	R	N	See HITSP/C83 Section 2.2.2.1 Person Information
C28-[CT3—8]	Procedures and Interventions	R	N	See HITSP/C83 Section 2.2.1.45 Procedures and Interventions
C28-[CT3—9]	Vital Signs	R	N	See HITSP/C83 Section 2.2.1.19 Vital Signs

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.

### 2.2.1.3 ED COMPOSITE TRIAGE AND NURSING NOTE

A Composite Emergency Department Triage and Nursing Note can be used in lieu of the individual Emergency Department Triage and Emergency Department Nursing Notes where the triage and the nursing notes are consolidated into a single document. The following table defines the HITSP constraints for an ED Composite Triage and Nursing Note.

The template identifier for this module is 2.16.840.1.113883.3.88.11.28.3

**Table 2-4 Data Mapping - ED Composite Triage and Nursing Note Content Modules**

Constraint ID	Content Module	HITSP Optional Entry	HITSP Repeatable Entry	Specification Reference
C28-[CT4—1]	Acuity Assessment	R	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.2
C28-[CT4—2]	Allergies	R	N	See HITSP/C83 Section 2.2.1.2 Allergy and Other Adverse Reactions
C28-[CT4—3]	Assessments	R	N	See HITSP/C83 Section 2.2.1.44 Assessments
C28-[CT4—4]	Chief Complaint	R	N	See HITSP/C83 Section 2.2.1.5 Chief Complaint
C28-[CT4—5]	Current Meds	R	N	See HITSP/C83 Section 2.2.1.12 Medications
C28-[CT4—6]	ED Disposition	R	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.10
C28-[CT4—7]	Family History	R2	N	See HITSP/C83 Section 2.2.1.25 Family History
C28-[CT4—8]	Functional Status Assessments	O	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1
C28-[CT4—9]	History of Past Illness	R2	N	See HITSP/C83 Section 2.2.1.4 History of Past Illness
C28-[CT4—10]	History of Pregnancies	R2	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4
C28-[CT4—11]	History of Present Illness	R	N	See HITSP/C83 Section 2.2.1.7 History of Present Illness
C28-[CT4—12]	Immunizations	R2	N	See HITSP/C83 Section 2.2.1.17 Immunizations
C28-[CT4—13]	Intravenous Fluids Administered	R2	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6
C28-[CT4—14]	List of Surgeries	R2	N	See HITSP/C83 Section 2.2.1.8 List of Surgeries
C28-[CT4—15]	Medications Administered	R2	N	See HITSP/C83 Section 2.2.1.15 Medications Administered
C28-[CT4—16]	Mode of Arrival	R	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2
C28-[CT4—17]	Patient Administrative Identifiers	R	N	See HITSP/C83 Section 2.2.2.1 Person Information



Constraint ID	Content Module	HITSP Optional Entry	HITSP Repeatable Entry	Specification Reference
C28-[CT4—18]	Person Information	R	N	See HITSP/C83 Section 2.2.2.1 Person Information
C28-[CT4—19]	Procedures and Interventions	R2	N	See HITSP/C83 Section 2.2.1.45 Procedures and Interventions
C28-[CT4—20]	Reason for Visit	R	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1.1
C28-[CT4—21]	Social History	R2	N	See HITSP/C83 Section 2.2.1.26 Social History
C28-[CT4—22]	Vital Signs	R	N	See HITSP/C83 Section 2.2.1.19 Vital Signs

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.

#### 2.2.1.4 ED PHYSICIAN NOTE

The following table defines the HITSP constraints for a Physician Note which is a document summary view of the Emergency Department Physician documentation.

The template identifier for this module is 2.16.840.1.113883.3.88.11.28.4

**Table 2-5 Data Mapping - ED Physician Note Content Modules**

Constraint ID	Content Module	HITSP Optional Entry	HITSP Repeatable Entry	Specification Reference
C28-[CT5—1]	Active Problems	R2	N	See HITSP/C83 Section 2.2.1.3 Problem List
C28-[CT5—2]	Assessments	R	N	See HITSP/C83 Section 2.2.1.44 Assessments
C28-[CT5—3]	Advance Directives	R	N	See HITSP/C83 Section 2.2.1.16 Advance Directives
C28-[CT5—4]	Allergies	R	N	See HITSP/C83 Section 2.2.1.2 Allergy and Other Adverse Reactions
C28-[CT5—5]	Assessment and Plan	C	N	See HITSP/C83 Section 2.2.1.23 Assessment and Plan.
C28-[CT5—6]	Care Plan	C	N	See HITSP/C83 Section 2.2.1.24 Plan of Care
C28-[CT5—7]	Chief Complaint	R	N	See HITSP/C83 Section 2.2.1.5 Chief Complaint
C28-[CT5—8]	Consultations	R	N	See IHE template Id 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.8
C28-[CT5—9]	Current Medications	R	N	See HITSP/C83 Section 2.2.1.12 Medications
C28-[CT5—10]	ED Diagnoses	R	N	See IHE template Id 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.9
C28-[CT5—11]	ED Disposition	R	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.10
C28-[CT5—12]	Family History	R	N	See HITSP/C83 Section 2.2.1.25 Family History
C28-[CT5—13]	History of Past Illness	R2	N	See HITSP/C83 Section 2.2.1.4 History of Past Illness
C28-[CT5—14]	History of Pregnancies	R2	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.5.3.4
C28-[CT5—15]	History of Present Illness	R	N	See HITSP/C83 Section 2.2.1.7 History of Present Illness
C28-[CT5—16]	Immunizations	R	N	See HITSP/C83 Section 2.2.1.17 Immunizations
C28-[CT5—17]	Intravenous Fluids Administered	R2	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.6
C28-[CT5—18]	List of Surgeries	R	N	See HITSP/C83 Section 2.2.1.8 List of Surgeries
C28-[CT5—19]	Medications Administered	R2	N	See HITSP/C83 Section 2.2.1.15 Medications Administered
C28-[CT5—20]	Medications at Discharge	R2	N	See HITSP/C83 Section 2.2.1.14 Hospital Discharge Medications
C28-[CT5—21]	Mode of Arrival	R	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.10.3.2
C28-[CT5—22]	Past Medical History	R2	N	See HITSP/C83 Section 2.2.1.4 History of Past Illness
C28-[CT5—23]	Patient Administrative Identifiers	R	N	See HITSP/C83 Section 2.2.2.1 Person Information
C28-[CT5—24]	Person Information	R	N	See HITSP/C83 Section 2.2.2.1 Person Information
C28-[CT5—25]	Physical Examination	R	N	See HITSP/C83 Section 2.2.18 Physical Examination
C28-[CT5—26]	Pertinent ROS	R2	N	See HITSP/C83 Section 2.2.20 Review of System
C28-[CT5—27]	Procedures Performed	R	N	See HITSP/C83 Section 2.2.1.45 Procedures and Interventions
C28-[CT5—28]	Progress Note	R	N	See IHE template Id 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.7
C28-[CT5—29]	Reason for Visit	R	N	See IHE templateId 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.1.1
C28-[CT5—30]	Referral Source	R	N	See IHE template Id 1.3.6.1.4.1.19376.1.5.3.1.1.13.2.3



Constraint ID	Content Module	HITSP Optional Entry	HITSP Repeatable Entry	Specification Reference
C28-[CT5—31]	Social History	R	N	See HITSP/C83 Section 2.2.1.26 Social History
C28-[CT5—32]	Test Results – Lab, ECG, Radiology	R	N	See HITSP/C83 Section 2.2.1.22 Diagnostic Results
C28-[CT5—33]	Vital Signs	R	N	See HITSP/C83 Section 2.2.1.19 Vital Signs

Optionality Legend: “R” for Required, “R2” for Required if Known or “O” for Optional, or “C” for Conditional. Conditional footnotes are further described below. Repeatable = “Y” for Yes, “N” for No.

## 2.2.2 GUIDELINES AND EXAMPLES

Emergency Department Encounter Summaries are not yet intended to replace the Emergency Department Chart as a complete legal document of care, but are intended as a collection of medical summaries with focused scope that can be used to fulfill a number of collaborative transfers of care.

*Examples of Emergency Department Encounter Summaries (EDES) Content may be found via the following links.*

- Triage Note: <http://wiki.ihe.net/index.php?title=1.3.6.1.4.1.19376.1.5.3.1.1.13.1.1>
- ED Nursing Note: <http://wiki.ihe.net/index.php?title=1.3.6.1.4.1.19376.1.5.3.1.1.13.1.2>
- Composite Triage and Nursing Note:  
<http://wiki.ihe.net/index.php?title=1.3.6.1.4.1.19376.1.5.3.1.1.13.1.3>
- ED Physician Note <http://wiki.ihe.net/index.php?title=1.3.6.1.4.1.19376.1.5.3.1.1.13.1.4>

## 2.3 STANDARDS

### 2.3.1 REGULATORY GUIDANCE

**Table 2-6 Regulatory Guidance**

Standard	Description
No applicable regulatory guidance	

### 2.3.2 SELECTED STANDARDS

**Table 2-7 Selected Standards**

Standard	Description
Integrating the Healthcare Enterprise (IHE) Patient Care Coordination (PCC) - Emergency Department Encounter Summary (EDES), Technical Framework Supplement 2009-2010, Trial Implementation August 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 Emergency Department Encounter Summary (EDES) enables the sharing of emergency department summary information between enterprises of a regional health network, and further describes how to map content in a CDA medical document into registry metadata. In the registry, healthcare providers publish pointers to documents stored in distributed repositories. Other healthcare providers may search and retrieve these and other documents. For more information visit <a href="http://www.ihe.net">www.ihe.net</a>
Health Level Seven (HL7) Version 3.0 Clinical Document Architecture (CDA) Release 2.0	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>



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

### 2.3.3 INFORMATIVE REFERENCE STANDARDS

**Table 2-8 Informative Reference Standards**

Standard Name	Description
No applicable informative reference standards	



### 3.0 APPENDIX

No additional information at this time.

REVIEW COPY



## 4.0 CHANGE HISTORY

The following sections provide the history of all changes made to this document.

### 4.1 DECEMBER 5, 2007

The changes in this cycle address the following comments:

- 536, 1218, 1220, and 1222

The full text of the comments along with the Technical Committee's disposition can be reviewed on the HITSP Public Web Site.

### 4.2 DECEMBER 13, 2007

Upon approval by the HITSP Panel on December 13, 2007, this document is now Released for Implementation.

### 4.3 AUGUST 20, 2008

This document has been modified to reflect the updated HITSP approach to categorizing standards as Regulatory Guidance, Selected Standards, and Informative References.

### 4.4 AUGUST 27, 2008

Upon approval by the HITSP Panel on August 27, 2008, this document is now Released for Implementation.

### 4.5 JUNE 30, 2009

Revised the document based on HITSP/TN903 Data Architecture

General Updates:

- Section 2.2.1 Data Mapping, added Data Constraint
- Appendix 3.0, addition link to C28 Emergency Care Summary Document Constraint
- Added constraint

Minor editorial changes were made to this construct. Removed boilerplate text for simplification. The term "actor" was replaced with "interface".

### 4.6 JULY 8, 2009

Upon approval by the HITSP Panel on July 8, 2009, this document is now Released for Implementation.

### 4.7 JANUARY 31, 2010

Revised the document to conform to the latest version of the HITSP Component template

Revised the document based upon the new IHE PCC EDES Supplement

Revised the document based upon HITSP Technical Committee work item to explicitly call out the HITSP Constraints associated with implementing the HITSP Emergency Care Summary Document Using IHE Emergency Department Encounter Summary (EDES) Component.

- General – Updated IHE reference Emergency Department Encounter Summary (EDES), Technical Framework Supplement, Trial Implementation Supplement August 10, 2009



- Updated Table 1-1 Reference Documents to include HITSP/TN903 Data Architecture
- Addition of constraint requirements in regards to IHE and HITSP templates
- Updated Section 2.2.1 Component Constraints to include of HITSP Constraint Content Modules for ED Triage Note, ED Nursing Note, Composite Triage and Nursing Note and ED Physicians Note
- Updated Table 2-1 Component Dependencies to include reference to HITSP/C83 Content Modules
- Updated Section 2.2.1 Data Mapping to specifically call out HITSP data mapping for ED Triage Note, ED Nursing Note, ED Composite Triage and Nursing Note and ED Physician Note
- Updated Section 2.2.2 Guidelines and Examples to call out IHE examples for ED Triage Note, ED Nursing Note, ED Composite Triage and Nursing Note and ED Physician Note
- Updated Selected Standards to include latest version of IHE PCC Technical Framework
- Updated Selected Standards to include Health Level Seven (HL7) Version 3 Standard: Clinical Document Architecture (CDA), Release 2.0 and Health Level Seven (HL7) Implementation Guide: CDA Release 2 – Continuity of Care Document (CCD)

