Aledade C-CDA Recommendations

Last Updated: April 2023

Purpose

To provide a guideline for practices that will be sending clinical data to Aledade using the HL7 Consolidated Clinical Document Architecture (C-CDA). The intent is to ensure that all required data for quality measures is received in a format that will meet the measure specifications. In addition, this data will support practices in their HCC Risk score calculations, ACO Population Health Initiatives, Medicare Stars requirements, and more.

Overview

Clinical Document Architecture (CDA) is a popular, flexible markup standard developed by Health Level 7 International (HL7) that defines the structure and provides a framework for the encoding, formatting, and semantics of electronic documents. It is a library of templates and can encompass information from a single point in time to an aggregation of one's medical history. C-CDA documents are generally represented in XML format. Structured data received using this format can be consumed by Aledade and parsed into the appropriate database tables. Aledade is version agnostic as it relates to C-CDAs. Aledade's preferred document template is the Continuity of Care Document (CCD), which represents a core data set of the most relevant administrative, demographic, and clinical information about a patient's healthcare over time (longitudinal/Patient as opposed to episodic/visit).

C-CDA Sections

All the desired sections for the C-CDA are listed in the table below labeled "Specifications". Two of the key sections for clinical data are Procedures and Results. These sections represent many of the clinical interactions with the patient as structured data.

Results represent the outcome of a test, or screening. For example, the results section could contain lab test results such as A1c or eGFR. Results could also contain the result of a screening such as a PHQ-9 Depression Screening. Results are generally represented as a LOINC code but may also be represented by a SNOMED code.
Procedures generally represent any billable activity that is not billed under an E&M (Evaluation and Management) CPT code. For example, the procedures section could include documentation of Colonoscopy procedures or Mammography procedures. For billing purposes, procedures are represented by CPT or HCPCS codes but in clinical documentation may be represented by LOINC or SNOMED codes.

Specific Data Elements

The more data elements we receive the better we are able to assist in population health management activities and respond quickly to changes in quality data. This is a short and not all-inclusive list of data elements we typically request to receive:

- Depression Screening using a standardized assessment tool such as the PHQ-9.
- Results of the depression screening (PHQ-9 total score, neg or pos. screening)
- Blood Pressure (systolic and diastolic)
- BMI
- Hemoglobin A1c (Glycosylated Hemoglobin)
- eGFR (glomerular filtration rate)
- Screening for Colon Cancer: Guaiac, Hemocult, FIT Test, Colonoscopy, etc.
- Screening for Breast Cancer: Mammogram
- Fall Risk Assessment

Transmission Latency

C-CDAs can be sent as frequently as desired but should be sent at least weekly (within 1-week of the encounter).

Specifications:

Requested C-CDA Document Template:	Description
We would prefer to receive a Patient Based C-CDA as opposed to an Event Based C-CDA.	Patient based C-CDAs provide a picture of the patient over time whereas encounter-based C-CDAs provide data on the data associated with a single encounter. In general, Aledade would like to receive all available data from the current encounter and historical encounters where possible.
Continuity of Care Document (CCD) 2.16.840.1.113883.10.20.22.1.2	The **Continuity of Care Document (CCD)** represents a core data set of the most relevant administrative, demographic, and clinical information facts about a patient's healthcare, covering one or more healthcare encounters. It provides a means for one healthcare practitioner, system, or setting to aggregate all the pertinent data about a patient and forward it to another to support the continuity of care by providing a picture of the patient's status over time.
Header	The header includes the metadata that details contextual information such as who created the document, the HL7 version, encounter information, and patient demographics.

Section Details:

Identifier	Name	Description	C-CDA hierarchy path
0. Clinical document Header			
0.1	Document ID	Unique Document Identifier	ClinicalDocument | id | extension [value]
0.2	SourceOID	HL7 registered OID for the practice/source	ClinicalDocument | id | root [value]
0.3	EffectiveTime	Document generated date time	ClinicalDocument | effectiveTime [value]
1. Patient Demographics (Personal Information)			
1.1	Patient OID	HL7 registered OID of the source generating the MRN	ClinicalDocument | recordTarget | patientRole | id | root [value]
1.2	Person ID	Unique Patient Identifier	ClinicalDocument | recordTarget | patientRole | id | extension [value]

1.3	Personal Address	Home street	ClinicalDocument | recordTarget | patientRole | addr | streetAddressLine [inner text]
1.4	Personal Address	Town/City	ClinicalDocument | recordTarget | patientRole | addr | city [inner text]
1.5	Personal Address	State	ClinicalDocument | recordTarget | patientRole | addr | state [inner text]
1.6	Personal Address	Zip	ClinicalDocument | recordTarget | patientRole | addr | postalCode [inner text]
1.7	Person Name	Last Name	ClinicalDocument | recordTarget | patientRole | patient | name | family [inner text]
1.8	Person Name	First Name	ClinicalDocument | recordTarget | patientRole | patient | name | given (first instance) [inner text]
1.9	Person Name	Middle Initial	ClinicalDocument | recordTarget | patientRole | patient | name | given (second instance) [inner text]
1.1	Gender	Administrative gender of patient	ClinicalDocument | recordTarget | patientRole | patient | administrativeGenderCode | Code [value]
1.11	Date of Birth	Date of Patients Birth	ClinicalDocument | recordTarget | patientRole | patient | birthTime [value]
1.12	Race Code	Race of Patient	ClinicalDocument | recordTarget | patientRole | patient | raceCode | displayName [value]
1.13	Race coding system	Coding system used to identify race code	ClinicalDocument | recordTarget | patientRole | patient | raceCode | codeSystem [value]
1.14	Education level	Education level of patient	
1.15	Ethnicity Code	Ethnicity Code	ClinicalDocument | recordTarget | patientRole | patient | ethnicGroupCode | displayName [value]
1.16	Ethnicity Coding System	Coding System corresponding to the Ethnicity of Patient	ClinicalDocument | recordTarget | patientRole | patient | ethnicGroupCode | codeSystem [value]
2. Language Spoken			

2.1	Primary Language	Spoken, written or understood primary language of patient	
3. Health Insurance Provider - Clinical Document | component | structuredBody | component | section | templateId | root [value] = 2.16.840.1.113883.10.20.1.9 Or 2.16.840.1.113883.3.88.11.83.101 Or 2.16.840.1.113883.10.20.22.2.18			
3.1	Insurance Type	HMO, PPO, etc.	
3.2	Payer Root		Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | performer | assignedEntity | id | root [value]
3.3	Health Plan Insurance Source ID	The coded identifier of the payer corresponding to the Health Plan Information Source Name	Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | performer | assignedEntity | id | extension [value]
3.4	Insurance Information Source Name	Name of the entity that is the source of information	Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | performer | assignedEntity | representedOrganization | name [inner text] **OR** Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | entryRelationship | act | text [inner text]
3.5	Member/Subscriber ID	Identifier assigned to patient by the health plan	Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | participant | participantRole | id | extension [value]
3.6	Subscriber Root		Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | participant | participantRole | id | root [value]
4. Allergy/Drug Sensitivity - Clinical Document | component | structuredBody | component | section | templateId | root [value] = 2.16.840.1.113883.10.20.1.2 Or 2.16.840.1.113883.3.88.11.83.102 Or 2.16.840.1.113883.10.20.22.2.6.1			
4.1	Adverse event date	Date of when allergy or intolerance became known	Allergy Low Date: Clinical Document | component | structuredBody | component | section | entry | entryRelationship | observation | effectiveTime | low [value] Allergy High Date: Clinical Document | component | structuredBody | component | section | entry | entryRelationship | observation | effectiveTime | low [high]
4.2	Product Code	Code describing the product	Clinical Document | component | structuredBody | component | section | entry | entryRelationship | observation | participant | participantRole | playingEntity | code | code [value] **OR**

			Clinical Document | component | structuredBody | component | section | entry | entryRelationship | observation | participant | participantRole | playingEntity | code | translation | code | code [value]
4.3	Status	Status of Allergy	Clinical Document | component | structuredBody | component | section | entry | act | statusCode | code [value]
4.4	Coding System Name	Coding system corresponding to the Allergy	Clinical Document | component | structuredBody | component | section | entry | entryRelationship | observation | participant | participantRole | playingEntity | code | codeSystemName [value] **OR** Clinical Document | component | structuredBody | component | section | entry | entryRelationship | observation | participant | participantRole | playingEntity | code | translation | codeSystemName [value]
4.5	Coding System OID	Coding system OID corresponding to the Allergy	Clinical Document | component | structuredBody | component | section | entry | entryRelationship | observation | participant | participantRole | playingEntity | code | codeSystem [value] **OR** Clinical Document | component | structuredBody | component | section | entry | entryRelationship | observation | participant | participantRole | playingEntity | code | translation | codeSystem [value]
4.6	Reaction Coded	Code describing the reaction	Clinical Document | component | structuredBody | component | section | entry | entryRelationship | observation | participant | participantRole | playingEntity | code | code [value] **OR** Clinical Document | component | structuredBody | component | section | entry | entryRelationship | observation | participant | participantRole | playingEntity | code | translation | code [value]
4.7	EventDateHigh	Date of when allergy or intolerance ended	Clinical Document | component | structuredBody | component | section | entry | *FIRST CHILD* | entryRelationship | *FIRST CHILD* | effectiveTime | high | value [value]
4.8	ProductText	Name of the product	Clinical Document | component | structuredBody | component | section | entry | FIRST CHILD | entryRelationship | FIRST CHILD | participant | FIRST CHILD | playingEntity | code | displayName [value] OR Clinical Document | component | structuredBody | component | section | entry | FIRST CHILD | entryRelationship | FIRST CHILD | participant | FIRST CHILD | playingEntity | code | translation | displayName [value]
5. Problem/Condition - Clinical Document | component | structuredBody | component | section | templateId | root [value] = 2.16.840.1.113883.10.20.1.11 Or 2.16.840.1.113883.3.88.11.83.103 Or 2.16.840.1.113883.10.20.22.2.5.1			
5.1	Problem Date	When the problem became active	Clinical Document | component | structuredBody | component | section | entry | act | effectiveTime | value [value] **OR** Clinical Document | component | structuredBody | component | section |

			entry | act | entryRelationship | observation | effectiveTime | low | value [value]
5.2	Problem Type	Fixed value to determine the existence of a problem	Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | value | displayName [value] **OR** Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | value | translation | displayName [value]
5.3	Problem Code	Coded describing the problem	Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | value | code [value] **OR** Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | value | translation | code [value]
5.4	Code System Name	Coding system corresponding to the Problem	Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | value | codeSystemName [value] **OR** Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | value | translation | codeSystemName [value]
5.5	Coding System OID	Coding system OID corresponding to the Problem	Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | value | codeSystem [value] **OR** Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | value | translation | codeSystem [value]
5.6	Treating Provider ID	NPI number for provider or providers treating the patient for condition	Provider ID: Clinical Document | component | structuredBody | component | section | entry | act | effectiveTime | performer | assignedEntity | id | extension [value] (if root [value] equals "2.16.840.1.113883.3.72.5.2") **OR** Provider ID: Clinical Document | component | structuredBody | component | section | entry | act | effectiveTime | informant | assignedEntity | id | root (if equals "2.16.840.1.113883.3.72.5.2") [value] | extension | root (if equals"2.16.840.1.113883.3.72.5.2") extension [value] **OR** Provider ID: Clinical Document | component | structuredBody | component | section | entry | act | effectiveTime | entryRelationship | observation | informant | assignedEntity | id | extension [value] {if root [value] equals "2.16.840.1.113883.3.72.5.2") --- ProviderOID: Clinical Document | component | structuredBody | component | section | entry | act | effectiveTime | performer | assignedEntity | id | root

			(if equals "2.16.840.1.113883.3.72.5.2") root [value] **OR** ProviderOID: Clinical Document | component | structuredBody | component | section | entry | act | effectiveTime | informant | assignedEntity | id | root {if equals "2.16.840.1.113883.3.72.5.2") [value] **OR** ProviderOID: Clinical Document | component | structuredBody | component | section | entry | act | effectiveTime | entryRelationship | observation | informant | assignedEntity | id | root {if equals "2.16.840.1.113883.3.72.5.2") [value]
5.7	Problem Status	Status of problem	Clinical Document | component | structuredBody | component | section | entry | act | statusCode | code [value] **OR** Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | entryRelationship (with typeCode = "REFR") | observation | value [value]
5.8	Priority Code	Code used to determine the principal/primary diagnosis for the visit	Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | priorityCode | code [value] OR Clinical Document | component | structuredBody | component | section | entry | act | priorityCode | code [value]
5.9	Priority Code System	Coding system for the priority code	Clinical Document | component | structuredBody | component | section | entry | act | entryRelationship | observation | priorityCode | codeSystem [value] OR Clinical Document | component | structuredBody | component | section | entry | act | priorityCode | codeSystem [value]
6. Medication - Clinical Document | component | structuredBody | component | section | templateId | root [value] = 2.16.840.1.113883.10.20.1.8 Or 1.3.6.1.4.1.19376.1.5.3.1.3.19 Or 2.16.840.1.113883.3.88.11.83.112 Or 2.16.840.1.113883.10.20.22.2.1.1 Or 2.16.840.1.113883.10.20.22.2.38			
6.1	Medication Start/Stopped	Whether or not a medication was discontinued	Start Date: Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | effectiveTime | low [value] Stop Date: Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | effectiveTime | high [value]
6.2	Coded Product Name	Code describing the product	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | code [value] **OR** Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | translation | code [value]

6.3	Coded Brand Name	Code describing the product as a branded or trademarked name	Medication Name: Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | displayName [value] **OR** Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | translation | displayName [value] **OR** Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | name [inner text]
6.4	Status of medication	Active, Discharge, Chronic, Acute, etc.	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | effectiveTime | statusCode | code [value]
6.5	Coding System Name	Coding system corresponding to the Medication	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | codeSystemName [value] **OR** Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | translation | codeSystemName [value]
6.6	Coding System OID	Coding system OID corresponding to the Medication	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | codeSystem [value] **OR** Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | translation | codeSystem [value]
6.7	Fill Status	Completed, never dispensed, etc.	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | effectiveTime | statusCode | code [value]
6.8	Medication Type	Type of medication administered to patient (Distinct template ID can be used to identify the type of medication)	Clinical Document | component | structuredBody | component | section | templateId | root [value]
7. Information Source			
7.1	Author Time	Time which information was created	

7.2	Author Name	Name of person who created the information	
7.3	Source Name	Name of organization that provided information	
8. Immunizations - Clinical Document | component | structuredBody | component | section | templateId | root [value] = 2.16.840.1.113883.10.20.1.6 Or **2.16.840.1.113883.10.20.22.2.2.1**			
8.1	Administered Date	Date immunization was administered or refused	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | effectiveTime [value] **OR** Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | effectiveTime (FIRST CHILD).[value]
8.2	Code System Name	Coding system corresponding to the Immunization	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | codeSystemName [value] **OR** Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | translation | codeSystemName [value]
8.3	Code System OID	Coding system OID corresponding to the immunization	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | codeSystem [value] **OR** Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | translation | codeSystem [value]
8.4	Immunization Name	Name	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | displayName [value] **OR** Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | translation | displayName [value]
8.5	Coded Product Name	Code describing the product	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | code [value] **OR** Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | consumable | manufacturedProduct | manufacturedMaterial | code | translation | code | code [value]

8.6	Status	Status of immunization	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | statusCode | code [value]
8.7	Negation Code	Indicator to identify negation of immunization.	Clinical Document | component | structuredBody | component | section | entry | substanceAdministration | entryRelationship | FIRST CHILD | code
9. Vital Signs - Clinical Document | component | structuredBody | component | section | templateId | root [value] = 2.16.840.1.113883.10.20.1.16 Or 2.16.840.1.113883.10.20.22.2.4			
9.1	Vital sign date	Date of observation	Clinical Document | component | structuredBody | component | section | entry | *FIRST CHILD* | component | *FIRST CHILD* | effectiveTime | value [value]
9.2	Vital sign type	The coded representation of the vital sign observation	Clinical Document | component | structuredBody | component | section | entry | *FIRST CHILD* | component | *FIRST CHILD* | code | code [value]
9.3	Vital sign result status	Status for vital sign observation (e.g., complete, preliminary, etc.)	Clinical Document | component | structuredBody | component | section | entry | *FIRST CHILD* | component | *FIRST CHILD* | statusCode | code [value]
9.4	Vital sign value	The value of the result including units of measure	Clinical Document | component | structuredBody | component | section | entry | *FIRST CHILD* | component | *FIRST CHILD* | value | value [value]
9.5	Unit	Unit of the value	Clinical Document | component | structuredBody | component | section | entry | *FIRST CHILD* | component | *FIRST CHILD* | value | unit [value]
9.6	Name	Name of the observation	Clinical Document | component | structuredBody | component | section | entry | *FIRST CHILD* | component | *FIRST CHILD* | code | displayName [value]
9.7	Coding System Name		Clinical Document | component | structuredBody | component | section | entry | *FIRST CHILD* | component | *FIRST CHILD* | code | codeSystemName [value]
9.8	Coding System OID		Clinical Document | component | structuredBody | component | section | entry | *FIRST CHILD* | component | *FIRST CHILD* | codeSystem [value]
10. Results - Clinical Document | component | structuredBody | component | section | templateId | root [value] = 2.16.840.1.113883.10.20.1.14 Or 2.16.840.1.113883.3.88.11.83.122 Or 2.16.840.1.113883.10.20.22.2.3.1			
10.10	Result Date/Time	Date and time of observation	Clinical Document | component | structuredBody | component | section | entry | organizer | effectiveTime | value [value] **OR** Clinical Document | component | structuredBody | component | section | entry | organizer | component | observation | effectiveTime | low [value]

10.20	Result Type	Code describing the observation performed or made	CodingSystemName: Clinical Document | component | structuredBody | component | section | entry | organizer | statusCode [value] **OR** Clinical Document | component | structuredBody | component | section | entry | organizer | component | observation | code | codeSystem [value]
10.30	Result Status	Status for observation (Complete, preliminary, addendum, etc.)	Clinical Document | component | structuredBody | component | section | entry | statusCode | code [value]
10.40	Result Value	The value of the result including units of measure	Clinical Document | component | structuredBody | component | section | entry | value | if value = null | if xsi:type = null then value [value] else if xsi:type = ST then InnerXML else if xsi:type = CD then Code [value]
10.50	Coding System Name	Coding system corresponding to the Lab result	Clinical Document | component | structuredBody | component | section | entry | organizer | code | codeSystemName [value] **OR** Clinical Document | component | structuredBody | component | section | entry | organizer | component | observation | code | codeSystemName [value]
10.60	Coding System OID	Coding system OID corresponding to the Lab result	Clinical Document | component | structuredBody | component | section | entry | organizer | code | codeSystem [value] **OR** Clinical Document | component | structuredBody | component | section | entry | organizer | component | observation | code | codeSystem [value]
10.70	Result Code	The code of the result	Clinical Document | component | structuredBody | component | section | entry | organizer | code | code [value] **OR** Clinical Document | component | structuredBody | component | section | entry | organizer | component | observation | code | code [value]
10.80	Unit	Unit of the value	Clinical Document | component | structuredBody | component | section | entry | value | unit [value] OR Clinical Document | component | structuredBody | component | section | entry | component | observation | value | if xsi:type <> null and xsi:type [value] = PQ then unit [value]
10.90	Name	Name of the lab test	Clinical Document | component | structuredBody | component | section | entry | code | originalText | InnerXML **OR** Clinical Document | component | structuredBody | component | section | entry | component | observation | code | displayName [value]
11. Encounter - Clinical Document | component | structuredBody | component | section | templateId | root [value] = 2.16.840.1.113883.10.20.1.3 Or 2.16.840.1.113883.10.20.22.2.22			

11.1	Encounter Type	Coded value describing the type of encounter	Clinical Document | component | structuredBody | component | section | entry | encounter | code [value]
11.2	Encounter Date	Date of encounter	Clinical Document | component | structuredBody | component | section | entry | encounter | effectiveTime | low [value] **OR** Clinical Document | component | structuredBody | component | section | entry | encounter | effectiveTime | value [value]
11.3	Coding System Name	Coding system corresponding to the Encounter	Clinical Document | component | structuredBody | component | section | entry | encounter | codeSystemName [value]
11.4	Coding System OID	Coding system OID corresponding to the Encounter	Clinical Document | component | structuredBody | component | section | entry | encounter | codeSystem[value]
11.5	Encounter Provider OID	OID corresponding to the provider	Clinical Document | component | structuredBody | component | section | entry | encounter | performer | assignedEntity | id | root (if value is "2.16.840.1.113883.3.72.5.2") [value]
11.6	VisitCode Display Name	Name corresponding to the code of the encounter	Clinical Document | component | structuredBody | component | section | entry | code | displayName [value]
11.7	Encounter End Date Time		Clinical Document | component | structuredBody | component | section | entry | effectiveTime | high | value [value]
11.8	DischargeCode		Clinical Document | component | structuredBody | component | section | entry | sdtc:dischargeDispositionCode | code [value]
11.9	DischargeCode System		Clinical Document | component | structuredBody | component | section | entry | sdtc:dischargeDispositionCode | codeSystem [value]
11.1	QualifierCode		Clinical Document | component | structuredBody | component | section | entry | code | qualifier | value | InnerXML
11.11	QualifierName		Clinical Document | component | structuredBody | component | section | entry | code | qualifier | name | InnerXML
11.12	Encounter Provider ID	NPI of encounter provider	Clinical Document | component | structuredBody | component | section | entry | performer | assignedEntity | id | extension (if root = 2.16.840.1.113883.3.72.5.2) [value]
12. Procedure - Clinical Document | component | structuredBody | component | section | templateId | root [value] = 2.16.840.1.113883.10.20.1.12 Or 2.16.840.1.113883.10.20.22.2.7.1			
12.1	Procedure ID	An identifier for this Procedure	Clinical Document | component | structuredBody | component | section | entry | act | id | extension [value]

12.2	Coded Procedure Type	Code describing the type of procedure	Clinical Document | component | structuredBody | component | section | entry | act | code | code [value]
12.3	Procedure Date	Date procedure was performed	Clinical Document | component | structuredBody | component | section | entry | act | effectiveTime | value [value]
12.4	Coding System Name	Coding system corresponding to the Procedure	Clinical Document | component | structuredBody | component | section | entry | act | code | codeSystemName [value]
12.5	Coding System OID	Coding system OID corresponding to the Procedure	Clinical Document | component | structuredBody | component | section | entry | act | code | codeSystem [value]
12.6	Provider OID	OID corresponding to the provider	Clinical Document | component | structuredBody | component | section | entry | act | performer | assignedEntity | id | root (if root is 2.16.840.1.113883.3.72.5.2) [value] **OR** Clinical Document | component | structuredBody | component | section | entry | act | informant | assigned entity | id | root (if root is 2.16.840.1.113883.3.72.5.2) [value]
12.7	Procedure Provider	NPI of provider who performed procedure	Clinical Document | component | structuredBody | component | section | entry | act | performer | assignedEntity | id | extension [value] (if root [value] is 2.16.840.1.113883.3.72.5.2) **OR** Clinical Document | component | structuredBody | component | section | entry | act | informant | assigned entity | id | extension [value] (if root [value] is 2.16.840.1.113883.3.72.5.2)
12.8	Code	Code corresponding to the procedure	Clinical Document | component | structuredBody | component | section | entry | code | code [value] **OR** Clinical Document | component | structuredBody | component | section | entry | code | translation | code [value] **OR** Clinical Document | component | structuredBody | component | section | entry | entryRelationship | FIRST CHILD | code [value]
12.1	Status	Status of the procedure	Clinical Document | component | structuredBody | component | section | entry | statusCode | code [value]
12.11	Name	Name of the procedure observation	Clinical Document | component | structuredBody | component | section | entry | code | originalText [InnerXML] **OR** Clinical Document | component | structuredBody | component | section | entry | entryRelationship | *FIRST CHILD* | displayName [value]

12.12	EndDate	End date of the observation	Clinical Document | component | structuredBody | component | section | entry | effectiveTime | high | value [value]
13. Social History - Clinical Document | component | structuredBody | component | section | templateId | root [value] = 2.16.840.1.113883.10.20.1.15 Or **2.16.840.1.113883.10.20.22.2.17**			
13.1	Social History Date	Range of time of which social history event was active	
13.2	Coded social history	Code describing the type of social history observation	Clinical Document | component | structuredBody | component | section | entry | observation | code [value]
13.3	Coding System OID	Coding system OID corresponding to the social history item	Clinical Document | component | structuredBody | component | section | entry | observation | code | codeSystem [value]
13.4	Coding System Name	Coding system name corresponding to the social history item	Clinical Document | component | structuredBody | component | section | entry | observation | code | codeSystemName [value]
13.5	Name	Name of social history item	Clinical Document | component | structuredBody | component | section | entry | observation | code | displayName [value]
13.6	Social History Observed Value	Value describing the social history (e.g., smoking history)	Clinical Document | component | structuredBody | component | section | entry | observation | value [inner text]
14. Mental Status Section - Clinical Document | component | structuredBody | component | section | templateId | root [value] = 2.16.840.1.113883.10.20.22.2.56			
14.1	Assessment Date	Date the assessment was completed	Clinical Document | component | structuredBody | component | section | entry | encounter | effectiveTime | low [value] OR Clinical Document | component | structuredBody | component | section | entry | encounter | effectiveTime | value [value]
14.2	Assessment	Name of the Assessment (i.e.: PHQ-9)	"Clinical Document | component | structuredBody | component | section | entry | code | originalText | InnerXML OR Clinical Document | component | structuredBody | component | section | entry | component | observation | code | displayName [value]"
14.3	Value	Total score of the assessment	Clinical Document | component | structuredBody | component | section | entry | value | if value = null | if xsi:type = null then value [value] else if xsi:type = ST then InnerXML else if xsi:type = CD then Code [value]

14.4	Relevant Reference Range	Reference Range for the Exam (i.e.: 0-4)	
14.5	Interpretation	Interpretation of score (i.e.: High / Low, Pos / Neg)	