Richard Esmond led the meeting. The discussion covered the Modeling Lab in various aspects.

The node size has metadata fields with upper and lower aspects. You can go to sometime completely different and go back to node size. The data will be changed. The unit of measure can be changed by going to clinical properties to change from inches to centimeters.

Some of the working labels are too long. The system broke. The labels will have to be shortened. The labels were lengthened because the description didn’t work. How should the label be shortened to accommodate the data and be clear at the same time. If a description is in comments, is it visible? A flag can be added to further describe. The SDC form can be generated to accommodate the descriptions needed.

Richard is at the Connectathon. He has several meetings to see how to partner Gemini, HL7 and the CI Group. He is working on how all parties can work together to support each other. Richard will provide more details in regards to the project.

A challenge of FHIR profiles is to get EPIC, Cerner and Allscripts to use in all aspects. Richard is working to establish a structure data capture form to produce a fire bundle. This bundle could be embedded into forms and produce the FHIR profile. A forms library can be used and filled out by a clinician. What will happen in EPIC and Cerner after the forms have been completed? It is stored in these locations, typically as a word document. Some of these ideas are being tested at the Connectathon that is currently taking place. In an SDC form filler, you can pick multiple points as to where you are sending the information, such as AJC.

An EMR, as an intermediary, can scrub all usable data. There needs to be a way to extrapolate the data for use in multiple places. How do you get to a FHIR bundle? Penrad captures all these data points already. These are from the ACR guidelines. Once the clinician hits save. This data would be transported to a JASAN file in the XML form. They can import this into a FHIR bundle. This would be able to be mapped to various fields. There would be custom work to take the data to a form.

There needs to be a way to define the questions in a questionnaire and the slots in a modeling form. This is a bi-directional transformation. Kurt and Richard are working on the solution to this. There should be some results in the next month. The declarative form will need direction to do the mapping. The FHIR profile and SDC questionnaire can be mapped at the same time to assist in pushing the data across. This is complicated with there is a one to many relationship. You cannot retrofit the content to satisfy the needs of the profile and form to get valid data.

The different communities are targeting different markets. How do you align these to various communities to share content? This would be a great advantage to everyone involved. The
challenges are similar. There is a way to harmonize the schema. How do you retain the functionality of everything? The gaps need to be identified in order to bridge them. More harmony has been created in the last year. FHIR uses very defined terminology. SDC doesn’t have the level of the FHIR project. The items can align with a bit of work, especially at the clinical level. The next two weeks will have an open source code developed this. If all goes well, a combination of standards can be presented in September. It is a very aggressive schedule, but it is doable.

Mark Kramer spoke about M Code. They started working a couple years ago with ASKO. They have signed up cancer centers to collect data with Cancer Link. The data collected has not be useful due to the structure of the system. They are working to acquire higher data in a more structured form. The implementation guides have come from this situation. The FHIR profiles started the specialization on breast cancer. This resulted a general cancer data, called M Code. The analysis and consensus process has been defined into a FHIR profiles and data elements. This is now being converted into a questionnaire form. A questionnaire using M Code would be packaged nicely in a way the clinician can readily understand. All of this needs to be adapted into a work-flow that is easily accessible to all.

The result of HL7 is that we are currently on track for a ballot in September.

The next meeting is January 30, 2019. The meeting on February 13 will be canceled.