Leveraging Prior CDA work to accelerate FHIR IG development & improve interoperability

For PACIO Community

Lisa Nelson, MS MBA
November 18, 2020
Objectives

- Background on CDA and C-CDA
- Background on PACP, C-CDA Advance Directives Section
- Basics on FHIR and Resources Relevant to Advance Directive Information
BACKGROUND ON CDA AND C-CDA
CDA Basics

**CDA – Clinical Document Architecture** is an HL7 document standard based on an early version of the HL7 V3 RIM. This standard specifies the structure and semantics of “clinical notes” for the purpose of exchange with other providers. One type of the document specified using this architecture is the CCD.

- XML syntax
- Based on HL7 V3 RIM v2.7 STATIC
- Adheres to 6 fundamental characteristics
CDA Basics

Data model is expressed in RIM classes.

Designs are expressed in something called Templates.

Templates are used to assess data conformance.
1. **Persistence** – A clinical document continues to exist in an unaltered state, for a time period defined by local and regulatory requirements (NOTE: There is a distinct scope of persistence for a clinical document, independent of the persistence of any XML-encoded CDA document instance).

2. **Stewardship** – A clinical document is maintained by an organization entrusted with its care.

3. **Potential for authentication** - A clinical document is an assemblage of information that is intended to be legally authenticated.

4. **Context** - A clinical document establishes the default context for its contents.

5. **Wholeness** - Authentication of a clinical document applies to the whole and does not apply to portions of the document without the full context of the document.

6. **Human readability** – A clinical document is human readable.
History of CDA Standard and the C-CDA IG

- 1997 – CDA got started
- 2000 – CDA Release 1
- 2005 – CDA Release 2 (RIM V2.07)
- 2007 – Clinical Care Document (based on ASTM CCR)+Health Story Docs
- 2009 – CDA R2 named in Meaningful Use Stage 1 (MU1)
- 2011 – Consolidated CDA v1.0 created (C-CDA)
- 2012 – C-CDA (C-CDA) named in MU2
- 2013 – CDA Release 3 (cancelled)
- 2013 – C-CDA R2.0 (included Patient Generated Document Header), C-CDA R2.1 (started)
- 2014 – C-CDA v2 likely to be named in MU3
- 2015 – C-CDA v2.1 named in MU3
- 2019 – CDA R2.1 Normative (RIM v2.35)
- CDA exchange estimated at 2.5 to 5.0 Billion documents/year
- 2020 – C-CDA v2.1 Companion Guide R2 names in ONC Cures Act Final Rule
CDA R2.0 (base standard), Consolidated CDA (C-CDA IG)

- Primary use cases: Patient Summary, Encounter Summary
- Usage: Very High (90M doc/mo), Maturity: Moderate
- Data Resolution: Much Higher than V2, Syntax: XML
- Data Quality: Better Potential (but low implementation consistency)
- CIRCA: 2010’s (Normative Standard since 2005, Release 2.1 (holding))
- Required by Meaningful Use and ONC Cures Act regulations

Core Principles of the HL7 Clinical Document Architecture

1. Persistence – A clinical document continues to exist in an unaltered state, for a time period defined by local and regulatory requirements (NOTE: There is a distinct scope of persistence for a clinical document, independent of the persistence of any XML-encoded CDA document instance).
2. Stewardship – A clinical document is maintained by an organization entrusted with its care.
3. Potential for authentication – A clinical document is an assemblage of information that is intended to be legally authenticated.
5. Wholeness - Authentication of a clinical document applies to the whole and does not apply to portions of the document without the full context of the document.

Consolidated CDA (C-CDA)

- C-CDA R1.0 (2011 Dec)
- C-CDA R1.1 (2012 Jul)
- C-CDA R2.0 (2014 Nov)
- C-CDA R2.1 (2015 Aug)
About CCD

CCD – Continuity of Care Document and Continuity of Care Records (CCR) are standard formats for exchanging key clinical information.

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 of the pertinent data about a patient and forward it to another to support the continuity of care.

The primary use case for the CCD is to provide a snapshot in time containing the germane clinical, demographic, and administrative data for a specific patient. The key characteristic of a CCD is that the ServiceEvent is constrained to "PCPR". This means it does not function to report new ServiceEvents associated with performing care. It reports on care that has already been provided. The CCD provides a historical tally of the care over a range of time and is not a record of new services delivered.
The Consolidated Clinical Document Architecture (C-CDA) provides common templates.

**Document Templates as of C-CDA R1.1:**
- Consultation Note
- Continuity of Care Document (CCD)
- Diagnostic Imaging Report
- Discharge Summary
- History and Physical
- Operative Note
- Procedure Note
- Progress Note
- Unstructured Document

**New as of C-CDA R2.0/R2.1:**
- Referral Note
- Transfer Summary
- Care Plan

These same building blocks can then be reused in other CDA document types, facilitating interoperability across a wide range of clinical uses and settings.
Document Templates

**Structured Document***

- Header
- Other Sections
- Procedures
- Results
- Plan of Care
- Advance Directives

**Minimally Structured Document**

- Header
- Other Sections
- Procedures
- Results
- Plan of Care
- Advance Directives

**Unstructured Document**

- Header

H = Human Readable Content
M = Machine Readable Content

* Continuity of Care Document, Consultation Note, Referral Summary, Transition of Care Document
C-CDA R2.1 Templates for Clinical Notes

Reorganized Using a SOAP Framework

<table>
<thead>
<tr>
<th>Subjective</th>
<th>Reason for Visit</th>
<th>Reason for Referral</th>
<th>Chief Complaint Reason for Visit</th>
<th>Chief Complaint</th>
<th>Health Concerns</th>
<th>Allergies &amp; Intolerances</th>
<th>Review of Systems</th>
<th>History Present Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>History Past Illness</td>
<td>Social History</td>
<td>Family History</td>
<td><strong>Objective</strong></td>
<td>Problem</td>
<td>Medical (Gen) History</td>
<td>Medications</td>
<td>Immunizations</td>
<td>Implants</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>Procedures</td>
<td>Results</td>
<td>Vital Signs</td>
<td>Admission Diagnosis</td>
<td>Admission Meds</td>
<td>Course of Care</td>
<td>Hospital Course</td>
<td>Hospital Consultations</td>
</tr>
<tr>
<td>Preoperative Diagnosis</td>
<td>Surgery Description</td>
<td>Op Note Surgical Procedure</td>
<td>Operative Note Fluids</td>
<td>Surgical Drains</td>
<td>Complications</td>
<td>Hospital Discharge Studies Sum</td>
<td>Hospital Discharge Physical</td>
<td>Advance Directives</td>
</tr>
<tr>
<td>Payers</td>
<td>Encounters</td>
<td>Physical Exam</td>
<td>Findings</td>
<td>Health Status Eval/Outcomes</td>
<td>General Status</td>
<td>Functional Status</td>
<td>Mental Status</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Assessment</td>
<td>Postprocedure Diagnosis</td>
<td>Postoperative Diagnosis</td>
<td>Discharge Diagnosis</td>
<td>Assessment &amp; Plan of Treatment</td>
<td>Goals</td>
<td>Planned Procedure</td>
<td>Instructions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Discharge Instructions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HL7 International**
A CCD records information over a range of time that likely includes multiple encounters.

A Transfer Summary records information that needs to be shared between care providers when a patient moves between health care settings.

The encompassing encounter for a Transfer Summary is the encounter from which the transfer in initiated.
<table>
<thead>
<tr>
<th>LOINC</th>
<th>Most General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation Note</td>
<td>ConsultDocumentType (2.16.840.1.113883.11.20.9.31)</td>
</tr>
<tr>
<td>Discharge Summary</td>
<td>DischargeSummaryDocumentTypeCode (2.16.840.1.113883.11.20.4.1)</td>
</tr>
<tr>
<td>History and Physical</td>
<td>HPDocumentType (2.16.840.1.113883.11.20.220)</td>
</tr>
<tr>
<td>Procedure Note</td>
<td>ProcedureNoteDocumentTypeCode (2.16.840.1.113883.11.20.6.1)</td>
</tr>
<tr>
<td>Progress Note</td>
<td>ProgressNoteDocumentTypeCode (2.16.840.1.113883.11.20.8.1)</td>
</tr>
<tr>
<td>Referral Note</td>
<td>ReferralDocumentType (2.16.840.1.113883.11.20.2.3)</td>
</tr>
<tr>
<td>Operative Note</td>
<td>SurgicalOperationNoteDocumentTypeCode (2.16.840.1.113883.11.20.1.1)</td>
</tr>
<tr>
<td>Transfer Summary Note</td>
<td>TransferDocumentType (2.16.840.1.113883.11.20.2.4)</td>
</tr>
<tr>
<td>Continuity of Care</td>
<td>Summary of Episode Note</td>
</tr>
<tr>
<td>Notes Section</td>
<td>Note Types 2.16.840.1.113883.11.20.9.68</td>
</tr>
<tr>
<td>Note Activity Entry</td>
<td>Note Types 2.16.840.1.113883.11.20.9.68</td>
</tr>
</tbody>
</table>
BACKGROUND ON PACP & C-CDA SUPPLEMENTAL TEMPLATES FOR ADVANCE DIRECTIVES INFORMATION
Ballot History and Development

- 2015 Began first Patient Generated Document – PACP
  - Large industry group, 15 different types of advance directives
- 2016 PACP R1 STU 1
- 2018 C-CDA Supplemental Templates for Advance Directives
- 2019 PACP R1 STU 2
Information Relationships: Combined View

Clinical Summary*
- Header
- Other Sections
- Procedures
- Results
- Plan of Treatment
- Advance Directives

Personal Advance Care Plan
- Header
- Personal Advance Care Plan
- Healthcare Agents
- GPP End-of-Life
- GPP After Death
- GPP for Personal Care Experience
- Witness & Notary

Care Plan
- Header
- Health Concerns
- Goals
- Interventions
- Evaluations & Outcomes
- Advance Directives

* Continuity of Care Document, Consultation Note, Referral Summary, Transition of Care Document
GPP = Goals, Preferences, and Priorities
Personal Advance Care Plan (PACP) Document

- Document Templates
- Section Templates
- Entry Templates
Approach

- Guidance supports all 3 levels of document representation
- Focus on standard coding for questions, not answers
- Focus on efficient access to needed patient generated information
- Not focused on computerized decision making, automation of human review, assessment, care planning processes
- Safety, Authenticity, Computer-aided Access
**PACP Entities**

- [1..1] recordTarget (CONF:4445-28460)
  - [1..1] patient (CONF:4445-28465)
  - [0..*] guardian (CONF:4445-28469)
  - [0..1] providerOrganization (CONF:4445-28476)
- [1..1] author (CONF:4445-28477)
  - [1..1] assignedPerson (CONF:4445-33366)
- [1..1] custodian (CONF:4445-28685)
- [0..1] dataEnterer (CONF:4445-28678)
- [0..*] informationRecipient (CONF:4445-28690)
- [0..*] participant (CONF:4445-28703)
  Healthcare Agent(s)
  Witness(es)
  Notary(ies)
  Assembler
- [0..*] authenticator (CONF:4445-28699)
- [0..1] legalAuthenticator (CONF:4445-28694)
Background on C-CDA Advance Directives (Supplemental Templates)

- Section Template
- Entry Template
# C-CDA R2.1 Templates for Clinical Notes

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<td>Hospital Course</td>
</tr>
<tr>
<td>Medications Administered</td>
<td>Anesthesia</td>
<td>Procedure Indications</td>
<td>Procedure Description</td>
<td>Procedure Specimens</td>
<td>Procedure Findings</td>
<td>Procedure Implants</td>
<td>Hospital Consultations</td>
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<td></td>
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<td></td>
<td>Plan of Treatment</td>
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<td>Hospital Discharge Instructions</td>
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<td>Discharge Diet</td>
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Data Elements from prior CDA work

- recordTarget
- guardian
- providerOrganization
- author
- dataEnterer
- custodian
- informationRecipient
- Organization
- Person
- legalAuthenticator
- authenticator
- participant: Assembler
- participant: Primary healthcare agent
- participant: First alternate healthcare agent
- participant: Second alternate healthcare agent
- participant: Witness
- participant: Notary
- Personal Advance Care Plan Header
- Personal Advance Care Plan
- Administrative Information Section 20200610
- GPP for End-of-Life or Severely Debilitating Condition Section 20200610
- GPP Personal Care Experience Section 20200610
- GPP Upon Death Section 20200610
- Healthcare Agent Appointment Section 20200610
- Personal Advance Care Plan Section 20200610
- Autopsy Observation 20200610
- Care Experience Preference 20200610
- Healthcare Agent Authority 20200610
- Healthcare Agent Selection 20200610
- MOLST Observation 20200610
- Organ Donation Observation 20200610
- Personal Health Goal 20200610
- Personal Intervention Preference 20200610
- Personal Priorities Organizer 20200610
- Advance Directives Section
- Advance Directives Section (entries required) (V4)
- Advance Care Planning Intervention (V1)
- Advance Directive Organizer (V3)
- Advance Directive Observation (V4)
- Obligation Instruction
- Prohibition Instruction
Advance Directives Value Sets

- **Advance Care Planning Services Grouping**
  Value urn:oid:2.16.840.1.113883.11.20.9.69.1.3
  Concepts from the Advance Care Planning Services Grouping Value Set can be used with the serviceEvent/code element in the header of the Summary of Care document when such services have been provided during the encounter.

- **ProcedureAct statusCode**
  urn:oid:2.16.840.1.113883.11.20.9.22 A ValueSet of HL7 actStatus codes for use with a procedure activity Value Set Source: [https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.22/definition](https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.22/definition)

- **Planned or Completed moodCode (Act/Procedure/Encounter)**
  urn:oid:2.16.840.1.113883.11.20.9.69.6 This value set includes the actMood codes required to express planned or completed acts, procedures, and encounters. Value Set Source: [https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.69.6/](https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.69.6/)

- **Advance Directives Categories**
  urn:oid:2.16.840.1.113883.11.20.9.69.4 Kinds of Advance Directives Value Set Source: [https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.69.4/definition](https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.69.4/definition)

- **Advance Directive Content Type SCT**
  urn:oid:2.16.840.1.113762.1.4.11155.5 Type of content that may be found in a person's advance directives. Value Set Source: [https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.11155.5/definition](https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.11155.5/definition)

- **Healthcare Provider Taxonomy (HIPAA)**
  urn:oid:2.16.840.1.114222.4.11.1066 The Health Care Provider Taxonomy value set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct Levels including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category. Providers may have one or more than one value associated to them. When determining what value or values to associate with a provider, the user needs to review the requirements of the trading partner with which the value(s) are being used Value Set Source: [https://vsac.nlm.nih.gov/valueset/2.16.840.1.114222.4.11.1066/expansion] Set Source: [https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.11155.5/definition](https://vsac.nlm.nih.gov/valueset/2.16.840.1.114222.4.11.1066/expansion)
  - ValueSet:
  - Personal And Legal Relationship Role Type urn:oid:2.16.840.1.113883.11.20.12.1 DYNAMIC (CONF:4445-28473)

11/19/2020
Value Sets Advance Directives Cont.

- **Healthcare Agent or Proxy Choices** [urn:oid:2.16.840.1.113762.1.4.1046.35](https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1046.35/definition) This value set identifies the healthcare agent or proxy roles that individuals commonly designate to empower surrogates to make medical treatment and care decisions when the individual is unable to effectively communicate with medical personnel or requires assistance with decision making. The intent of this value set is to identify the questions used to determine an individual's choices for a healthcare agent or proxy, including the designation of surrogates. The value set is defined by this list of concepts. Value Set Source: [https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1046.35/definition](https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1046.35/definition)

- **Obligation or Prohibition Instruction Type** [urn:oid:2.16.840.1.113883.11.20.9.69.17](https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.69.17/expansion) The types of obligation instructions that may be provided by a patient or by a patient's healthcare agent when the patient can't communicate, or by a care provider acting on behalf of the patient's interest when a healthcare agent has not been appointed. Value Set Source: [https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.69.17/expansion](https://vsac.nlm.nih.gov/valueset/2.16.840.1.113883.11.20.9.69.17/expansion)

- **InstructionActStatus** [urn:oid:2.16.840.1.113762.1.4.1115.2](https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1115.2/expansion) This value set holds the state model concepts for an Obligation Instruction or Prohibition Instruction. These are instructions that a patient, or a patient's healthcare agent or other type of surrogate decision-maker may decide to make when the patient is unable to communicate. Value Set Source: [https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1115.2/expansion](https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1115.2/expansion)
FHIR BASICS → LEVERAGING PRIOR WORK
Key Terms in Interoperability

- **Client**: software that connects to another system.

- **Server**: a computer system the client connects to / interacts with.

- **Use Case**: a hypothetical scenario that illustrates a problem by providing clinically relevant details about a patient and defining the interactions between the patient and the healthcare system to achieve a goal.

- **Implementation Guide**: provides instructions for developers on how to design and implement technological solutions to achieve the goal identified in the use case.

- **Reference Implementation**: the technological solution developers design using the implementation guide as a template.

- **Connectathon**: an opportunity for multiple vendors to review the implementation guides, test the client and/or server software in a structured environment and provide constructive feedback; it can be described as a “test kitchen” and the implementation guide as a “recipe” that can be refined by participants.

- **Data Element**: most granular level at which a piece of data is represented (e.g., BIMS total score, gender, insulin dosage, systolic/diastolic blood pressure, etc.)

- **Value Set**: collection of data elements, represented by a set of codes from one or more code systems (e.g., CPT codes, LOINC codes, ICD codes, etc.), that can be used and re-used to exchange data between systems.
Resources, Extensions, and Profiles...OH MY!

- A **RESOURCE** is the smallest *unit of exchange* that 'makes sense' in interoperability – such as an observation, a patient, or a condition

  **Resource Examples:**
  - Administrative
    - Patient, Practitioner, Organization, Location, Claim
  - Clinical Concepts
    - Allergy Intolerance, Condition, Family Member History, Care Plan

  **Non-examples:**
  - Gender (Too small)
  - EHR (Too big)
  - Blood Pressure (Too specific)
  - Intervention (Too broad)

- An **EXTENSION** is an additional component that helps further define data (i.e. patient-birth place)

- A **PROFILE** is a group of extensions applied to customize a resource

**R4** (the most current version of FHIR) consists of **143 resources**
Recap: Resources are the Building Blocks of FHIR

- Developers can “bundle” multiple resources together to transmit only select information from a large amount of data (e.g. an EHR)

- Each resource is comprised of one or more data elements
  - Patient = Resource
    - Data Elements: Patient name, gender, race, address, CMS ID #, etc.

- Extensions supplement existing resources
  - Patient = Resource + Extension = Self-care
    - Data Elements: Eating, Oral Hygiene, Toileting hygiene, Wash upper body, Shower/bathe, Upper body dressing, Lower body dressing, Putting on/taking off footwear

Source: Introduction to FHIR™ – Grahame Grieve
PAC Functional Status Profile Example

**Patient**
Data Elements: Patient name, gender, race, marital status, address, birthdate, CMS ID #

**Extension**
Self-care
Data Elements: Eating, Oral Hygiene, Toileting hygiene, Wash upper body, Shower/bathe, Upper body dressing, Lower body dressing, Putting on/taking off footwear

**Resource**
Practitioner
Data Elements: Practitioner name, address, identifier

**Resource**
Diagnostic Report
Data Elements: Observation, Diagnostic Report, Specimen, Imaging Study, Body Structure, Molecular Sequence, Questionnaire/Response

**Resource**
Mobility
Data Elements: Eating, Oral Hygiene, Toileting hygiene, Wash upper body, Shower/bathe, Upper body dressing, Lower body dressing, Putting on/taking off footwear
FHIR supported interfaces

- REST – CRUD with Resources
- Documents – Point-in-Time view of information, must be persisted
  - DocumentReference, Binary | Composition
- Messaging – no expectation that the receiving system will persist the message resource payload (if not documents)
- Services – light-weight messaging
How to think about CDA and FHIR together?

CDA Data Class = FHIR Resource
CDA Template = FHIR Profile
Advance Directives Information FHIR IG
Use Cases

- **Create and Share**
  - Advance Directive Information
  - Encounter-Oriented Patient Instructions

- **Receive, Query&Retrieve, Request&Retrieve**
  - Advance Directive Information
  - Encounter-Oriented Patient Instructions
Phase I: Share existing forms of ADI via FHIR
Document Paradigm – REST with DocumentReference

Resource
A reference to a document of any kind for any purpose. Provides metadata about the document so that the document can be discovered and managed.

Resource

Document Reference

Resource

Binary

Other Header Resources

Patient
Phase II: Full FHIR Resources

A reference to a document of any kind for any purpose. Provides metadata about the document so that the document can be discovered and managed.

Entries as FHIR Resources

REST operations on individual FHIR Resources
Corresponding FHIR Resources (TBD)
Leverage prior document work

<table>
<thead>
<tr>
<th>PACP, C-CDA</th>
<th>FHIR</th>
</tr>
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<tbody>
<tr>
<td>Document Header Templates</td>
<td>DocumentReference</td>
</tr>
<tr>
<td>Document StructuredBody Section Templates</td>
<td>Composition (Sections)</td>
</tr>
<tr>
<td>Entry Templates</td>
<td>FHIR Resource Profiles (US Core + others TBD)</td>
</tr>
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## Leverage Personal Advance Care Plan Entry Templates (Personal Planning Context)

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<thead>
<tr>
<th>PACP Entry Templates</th>
<th>FHIR Resources to be profiled</th>
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<tbody>
<tr>
<td>Healthcare Agent Selection</td>
<td>Consent</td>
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<tr>
<td>Healthcare Agent Authority</td>
<td>Consent</td>
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<tr>
<td>Personal Intervention Preference</td>
<td>Observation→Procedure</td>
</tr>
<tr>
<td>Personal Health Goal</td>
<td>Goal</td>
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<tr>
<td>Personal Priorities Organizer</td>
<td>List</td>
</tr>
<tr>
<td>Care Experience Preference</td>
<td>Observation</td>
</tr>
<tr>
<td>Organ Donation Observation</td>
<td>Observation</td>
</tr>
<tr>
<td>Autopsy Observation</td>
<td>Observation</td>
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<tr>
<td>MOLST Observation</td>
<td>Observation</td>
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</table>
Leverage C-CDA Advance Directives Entry Templates (Care Encounter Context)

### Plan of Treatment | Interventions Section

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Consent → Procedure</th>
<th>Contract ?</th>
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<tbody>
<tr>
<td>Advance Care Planning Intervention</td>
<td>Procedure</td>
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<tr>
<td>Obligation Instruction</td>
<td>Consent → Procedure</td>
<td>Contract ?</td>
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<tr>
<td>Prohibition Instruction</td>
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<td>Contract ?</td>
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### Advance Directives Section

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<th>List</th>
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<tr>
<td>Advance Directives Observation</td>
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QUESTIONS?

Lisa Nelson
MaxMD

LNelson@max.md