Implementer Leader/Topic Plan Template

1. Topic Name?
2. Follow-up on prior IAT action items
3. What problem are you trying to solve?
4. How are you planning on leading the discussion? (What is your planned approach, what steps will you take?)
5. What samples do you plan to use to support the discussion?
6. What actions do you want attendees to do before or what samples or examples do you want them to bring to the session?
7. What actions are you expecting to happen as a result of your session?
8. No preparation needed

Agenda

- Review of Topics from July 2020 C-CDA IAT
  - Topic 1: Life to Death in CDA
  - Topic 2: Payer Section – how to identify Payers? Represent a person’s insurance card information
  - Topic 3: Alternate Identifiers
  - Topic 4: Encounter Document Creation
  - Topic 5: USCDI Clinical Notes Questions
  - Topic 6: C-CDA Participation mappings to FHIR Resources
CMG Follow-up Commitment

- Tracking IAT Action Items on [CMG Confluence](#)
- 11 Action Items
- 2 Completed
- 5 Started – making progress
- 1 Started – progress blocked (**Escalation**)  
- 3 Pending – no action yet

Topic 1: Life to Death in CDA

- Need example of “best practice” representation of a deceased person in a document header.
- Rubric Rule has been suggested.

Topic 2: Payer Section – How to identify Payers, Person’s Insurance Card Information

- Working with Linda to create an example of the alternateIdentifier for use with representing Payer’s identifier.
- Stalled on working with FM to determine how to represent a person’s insurance card information.
  - Doing work in FHIR R5 which may bring clarity that could be backported to C-CDA.
Topic 3: Alternate Identifiers

- Extension definition started, needs to be improved and then implementation needs to be finished.
- Working with Linda to create an example for use with representing Payer's identifier.

New github repo for CDA Schema

https://github.com/HL7/cda-core-2.0

Topic 4: Encounter Document Creation

- Continuing to work with Carequality/CommonWell Communities. What can implementers commit to offering and sharing other clinical note document types?
**Topic: 5: USCDI Clinical Notes**

- Revisions are being proposed to USCDI V1

**USCDI V1 Clinical Notes comments from Regenstrief Institute**

Add code for each note type. Some are general USCDI concepts as well as more specific concepts that vary by setting, specialty, etc. In most clinical situations, use of a more specific code is encouraged. They are managed by LOINC and included in the USCDI structural package.

**USCDI V2 New Data Class recommendation from Regenstrief Institute**

- New Imaging Data Class
  - Imaging Order – The request by a clinician for an imaging procedure to be performed for a patient. Applicable standard would be CPT or LOINC.
  - Imaging Data – The data that represents the imaging study itself. Applicable standard would be DICOM.
  - Imaging Report – Clinical documentation of an imaging study that includes the study that was performed, reason, findings, and impressions. Applicable standard would be LOINC.
**Topic 6: C-CDA Participant Mappings to FHIR Resources**

- Issue is being escalated through Patient Care WG

**New US Realm Project Manager**

C-CDA Maintenance roadmap topics:
- Errata Releases (technical corrections)
- Value Set Updates (updates that only impact dynamically bound value sets)
- Minor Updates (a point release to absorb available template changes)
- Major Updates (like going to the Web Publication)
- Companion Guide Updates
- Rubric Rule Updates