Implementer Guidance:
Expanding the possibilities and evolving the guidance.
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COMMONWELL/CAREQUALITY GUIDANCE UPDATE
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Agenda
- CommonWell-Carequality Joint Document Content Work Group
- What is Project CLARE?
- Guidance examples covered in Project CLARE
- ONC Scorecard Improvements
What is the Joint Document Content Work Group?

- Carequality and CommonWell launched in 2018
- Participation from clinicians, vendors, standards SMEs
- Solve common problems with content
  - Too large C-CDA documents
  - Absence of clinical notes
  - Need for encounter summaries
  - Need for version management
- Output is best practices guide
  - Each exchange incorporates into its governance process to adopt or not

What is the group’s “lane”?

- Top level operational spec for exchanges; can be more prescriptive
- Can address problems crossing multiple standards lanes
  - Content: HL7 CDA, C-CDA documents
  - Query and retrieval: IHE Document Sharing
  - Relationships between EHR state, queries, and generated content
- Can feed back issues to standards bodies
  - E.g., consider for C-CDA Companion Guide

Work so far

- 2.0 rev (and rename) of previous guide; work done in 2020, currently being finalized
- Guidance for dynamically generating documents, aka “on-demand”
- Guidance for generating Encounter Summaries through the lifecycle of an encounter
- Guidance for “Patient Summaries”; generation with and without date ranges
- Guidance for interoperable lab results
- Guidance for “Encounter Summaries”; Progress Notes and Discharge Summaries
- Guidance for Clinical note placement
- How dates in queries relate to returned/generated documents
- Guidance for Smart Senders and Resilient Receivers

Aug 2021: Concise Consolidated CDA: Deploying Encounter Summary

Feb 2019: Concise Consolidated CDA: Deploying Encounter Summary
What would you like to see next?

- Encounter summary snapshots through the lifecycle of the encounter?
- Tracing labs from orders through pending and actual results?
- An entire workflow of IHE query for metadata, IHE retrieve for document, and the document itself?
- Any requests?

What is Project CLARE?

CLARE is a cross-community collaborative project focused on clarifying the vision for improved care coordination and creating a learning health system. CLARE is developing detailed examples that demonstrate how implementers can use standards-based communications to enable more efficient and effective information exchange for all care team members while empowering patients to actively participate in their care.

CLARE provides high-quality, synthetic patient data in the context of a specific healthcare use case exposing a valuable new level of coordination rarely seen by clinicians in today’s health care system while lowering the cost of error and improving patient experience of care.

Project CLARE information and resources can be found by clicking here.
Guidance examples covered in Project CLARE

Some of the guidance examples that are covered in Project CLARE:
1. Proper Text Linking (Commonwell Carequality IG and Companion Guide)
2. ID Preservation (Commonwell Carequality IG)
3. Clinical Note Templates (Companion Guide)
4. Section Time Range (Companion Guide)
5. Author Provenance (Companion Guide)
6. Care Team (Companion Guide)

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Guidance examples: Proper Text Linking

Objective: Maintain proper references between coded values and narrative

Importance: Processing and validating C-CDA documents with structured entries

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Guidance examples: ID Preservation

Objective: Maintain act/observation IDs across documents

Importance: Enables receivers to accurately identify data that has been previously reported
Guidance examples: Clinical Note Templates

Objective: Use of new Notes Section and Notes Activity for common clinical note types
Importance: Clinical notes are a critical part of the patient record and USCDI v1

Common Clinical Note Types
- Consultation note (11488-4)
- Referral note (57133-1)
- Progress note (10506-3)
- Procedures note (28570-0)
- Discharge summary (11942-5)
- History & Physical (34117-2)
- Imaging narrative (15728-0)
- Lab/path narrative

Guidance examples: Section Time Range

Objective: Use of Section Time Range to represent date and time range of data
Importance: Provides a mechanism to communicate what data is included in a section

Guidance examples: Provenance – Author Participation

Objective: Record Provenance in an Author Participation
Importance: Critical for maintaining Data Provenance

The author of a goal

The author of the clinical document
Guidance examples: Care Team

Objective: Use of new Care Team Organizer
Importance: Defines the care team name, participants and lead

Demonstrates Care Team:
- Organizer
- Team Name
- Team Status
- Team Lead

Guidance examples: Care Team (cont’d)

Care team members are components of a care team (within the CareTeam organizer)

Demonstrates Care Team Members:
- Member Status
- Member effectiveTime
- Member Attributes (Name)
- Member Role (function on the team)

ONC Scorecard Improvements

Improvements needed in the ONC Scorecard:
1. The validator needs to validate templates in a more modular way. Most templates are open templates and can be used anywhere. The validator should trigger off an asserted template, using the templateId in the assertion to apply the implied conformance constraint checking.
2. C-CDA Document Types. The validator skips many common sections when it does not see a specific document type.
3. Option for One-click Scorecard to provide the full report—same as the regular ONC Scorecard.
NEW CDA STYLESHEET FOR RENDERING DATA PROVENANCE

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Requirements

Provenance is a required data element in USCDI v1; all USCDI data elements must also be visible to users.

The ONC offered the following guidance around the display of provenance info: Provenance Author Participation template in the C-CDA Companion Guide has to be used to record Provenance data for all USCDI data classes and elements. When desired by a Provider or a Patient, vendors should be able to display the Provenance data. In summary for VDT, the Health IT system should be able to demonstrate the capability to display Provenance data.

Challenges

- Vendors could parse all provenance data in all USCDI elements and integrate it into downstream workflows, but this is hard.
- Any solution needs to handle all discrete Provenance Author Participation templates from other sources—that is, just adding provenance to your own document narratives wouldn’t be enough.
Solution

- Created new USCDI feature branch of CDA stylesheet.
- Currently in alpha, looking for implementer feedback.
- Enables provenance display out of the box by parsing provenance author entries linked to narrative elements and converting them to tooltips.

Follow-Ups & Conclusion

- How useful is this to implementers? What other solutions, if any, exist for provenance display?
- Stylesheet available for download on GitHub; leave feedback there too!
- Is there value in this maturing beyond alpha and being maintained?

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Break until 11:30 am ET

Poll answers for: What’s your favorite camping location?
Balancing many priorities