Medication Statement Fhir Resource Proposal
Contents

- 1 medicationStatement
  - 1.1 Owning committee name
  - 1.2 Interested Work Groups
  - 1.3 FHIR Resource Development Project Insight ID
  - 1.4 Scope of coverage
  - 1.5 RIM scope
  - 1.6 Resource appropriateness
  - 1.7 Expected implementations
  - 1.8 Content sources
  - 1.9 Resource Relationships
  - 1.10 Timelines
  - 1.11 gForge Users
medicationStatement

Owning committee name
Pharmacy

Interested Work Groups

- PHER (Immunizations)
- Patient Care

FHIR Resource Development Project Insight ID
855

Scope of coverage

Making assertions about Medicines that Humans are believed to be taking or to have taken.

The scope of "Medicines" is as defined by the medicines resource and at its simplest can be taken to be an identified product. This allows very broad interpretation and can cover non-prescribed medication, herbal products, diet supplements, illicit drugs, and even some products that may be classified as devices. The key distinguishing characteristic is that the product is consumed and cannot be reused.

An medicationStatement may be a single event or may be a series of events over a period of time. It may carry a reference to a prescription or a dispense but this is not required.

RIM scope

medicationStatement corresponds to the RIM Acts of Substance Administration (SBADM) as constrained in the Pharmacy Domain model Medication Statement Record Notification PORX_RM040010UV

Resource appropriateness

Prescription is one of the three core steps of use of medicines, the other two being Dispensing (or Supply) and Administration. In many settings the three steps are performed by separate people, and are frequently recorded by separate software systems. Prescription records are a core part of knowing what medication a patient is supposed to receive - having a standard format for this is essential. There is a well established set of attributes that are always required.

Collection of Medication Statements is a key part of many episodes of care. The initial contact between patient and carer is when a record is built up of the medication they are currently taking, or which they have recently taken. Patients themselves, their relatives and other health care professionals may all contribute to this record.

The pharmacy group spent some time discussing the extent to which the attributes for Medication Statement and Medication Administration overlapped and came to the conclusion that there is a need to express these attributes as part of distinct resources. A primary driver here is that Medication Administration records may be treated as absolute statements of truth; in contrast Medication Statements must be treated with caution since they may be based upon a confused or partial recollection of facts or on assumptions that are actually invalid.

Expected implementations

This is a key resource required by almost all Healthcare systems. As such it is key for any system scoped by CCDA.

Content sources

- Existing normative V3 Pharmacy RMIMs
- HL7 v2 specifications
- Existing specifications in Canada, The Netherlands and UK
- NCPDP specifications
- Developing specifications in Australia
- Some commercial systems

Resource Relationships

medicationStatement is a core part of building up an EHR.
Timelines
Ready for second ballot September 2013

gForge Users
hugh_glover, Jean-Henri Duteau