Sept 2018 WGM - Patient Care Agenda and Minutes

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Agenda

Quarter	Room	Size	Agenda	Hosting	Chair /Scribe (Attending)	Invitation Status
Mon Q1			Plenary		Not Applicable	
Mon Q2			Plenary		Not Applicable	
Mon Lunch	Annapolis		FHIR Committers	FHIR-I	Michelle	
Mon Q3a			Mega Report Out	EHR	Not Applicable (Laura/Emma)	Accepted: PC
Mon Q3b	Guest Room 317	10	V2 Chapter 11 & 12 (Ask Amit to let OO know) PSS for coordinated DAM (allergy/immunization)	PC	Jay/Michael T	
Mon Q4	Constellation CD		PC/OO FHIR Trackers • GF#17576 - Observation.comment cardinality (vs Observation note) • ValueAttachment vs Media • Guidance for interpretation of an observation using Codes, Coding, Components, Precondition or Panels. • Plus on the workflow side a question on tweaking whether to tweek the definition of event status - unknown definition • GF#17359 Task and Procedure resources completely overlap - need clarifying descriptions (in person)	OO	Not Applicable (Michelle attend)	Accepted: PC
Tues Q1	Constellation CD	40	CIMI • POC Wound - addressing ballot comments	PC	Jay/Laura	Accepted: LHS, CIMI, EC
Tues Q2	Columbia	40	Clinical Notes in FHIR (continuation from Jan 2018) * Update on the Connectathon * Update from Argonaut Evelyn Gallego - Introduction to CMS Electronic Medical Documentation Interoperability (EMDI) Initiative EMDI Pilots (5 minutes)	PC	Michelle /Emma	SD
TuesQ3	Constellation E	30	FHIR Admin + FHIR Trackers Follow-up / old business • GF#17359 Task and Procedure resources completely overlap - need clarifying descriptions (this is the PC tracker for Procedure) • GF#19109 Task and Procedure need clarifying boundary descriptions (this is the OO tracker for Task) – resolved in Mon Q4 during joint OO/PC • GF#16190 - prior motion (to find tracker persuasive) was defeated, but gForge requires a second motion (to find tracker not persuasive) in order to have a successful vote CommunicationRequest • GF#17902 Description for Communication resource may need to be updated • GF#13936 CommunicationRequest - intent value set Goal-related trackers • GF#17755 Add support for conveying whether the goal is a one-time goal or an on-going goal 2018-Sep Core STU • GF#17756 Consider whether Goal.status should be split into 2 elements 2018-Sep Core STU	PC	Michelle /Michelle	Accepted: FHIR-I
Tues Q4a	Constellation AB	50	Negation Core binding strength issues (harmonization across realms and standard families) Other vocab topics (e.g. Clinical Status Value Set) Gaps in Care CQI requested Procedure/QDM discussion (if time)	PC	Jay/Emma	Accepted: Pharm, SD, **CQI**, CIMI, CG, Vocab, OO
Tues Q4b			"Podiatry Functional Profile" Joint Meeting (EHR WG hosting): Attachments, CIMI, CQI, O&O, Patient Care, Pharmacy	EHR		**PC did not respond**

Wed Q1	Columbia	30	FHIR Trackers - allergy and condition Condition • GF#18833 Remove clinicalStatus requirement constraint - STU #31 2018-Sep Core STU (in person - Corey Spears) • GF#18832 Add more clarity to Condition.category - STU #30 2018-Sep Core STU Allergy • GF#18819 Placeholder. There are some types that may be in issue - STU #17 2018-Sep Core STU • GF#18831 Remove clinicalStatus requirement constraint - STU #29 2018-Sep Core STU (in person - Corey Spears)	PC	Michelle /Michelle	Declined: OO
Wed Q2a	Executive Boardroom		Joint with PA • Care Team (LHS) • Resource VerificationResult (PA please provide overview)	PA	Not Applicable (Michelle /Emma)	Accepted: PC
Wed Q2b	Chesapeake B		Blood Products, tissue and biological product (update needed) V2-To-FHIR	OO		OO, II, CG, BR&R
Wed Lunch			Clinicians on FHIR Lunch (Russ will reserve room) Invite David Hay - Stephen will send invite		Laura/Stephen /George	N/A
Wed Q3a	Guest Room 317		OO owned FHIR resource review GF#15726 add unit and total cost to ServiceRequest (joint with FM/OO/PC)	OO	Not Applicable (Michelle/Jay)	PC CDS, CQI, FHIR-I
Wed Q3b			Common Clinical Registry Framework	CIC	Not Applicable (Laura)	N/A
Wed Q4	Baltimore	30	FHIR Trackers FamilyMemberHistory • GF#18848 ValueSet for BirthSex (i.e.Clinical Sex) should be XX|XY|other (e.g. XXY, XYY) rather than gender (male/female) - STU #193 2018-Sep Core STU • GF#18849 BirthSex may be more appropriately modelled under Observation - STU #194 2018-Sep Core STU • GF#18850 FamilyMemberHistory.gender should be mapped to AdminitrativeGender valueset, not BirthSex valueset - STU #195 2018-Sep Core STU • GF#18855 What's reason for age of family member - STU #204 2018-Sep Core STU • GF#18856 What's reason for deceasedDate of family member - STU #205 2018-Sep Core STU • GF#18857 Revamp FamilyMemberHistory.condition - STU #206 2018-Sep Core STU • GF#18858 Change to be condition-centric - STU #207 2018-Sep Core STU	PC	Michelle /Michelle	N/A

Thurs Q1a	Constellation E	35	CarePlan report out
			
			https://imeet.webex.com/join/laura.heermann
			
			• Care Plan -
			  • Dental Interoperability Investigative Project - jointly between the ADA and HL7 - related to Care Planning
			  • CDA
			  • HL7 C-CDA 2.1 Care Plan Document Template - Lisa Nelson
			  • HL7 CDA R2 Personal Advanced Care Plan Document - Lisa Nelson
			  • CDA 2.1
			  • Collaborative Review of CDA Management Group Pilot Template Review.
			  • Pharmacy Templates CDA IG
			  • Nutrition Template update
			  • gender identity
			  • primary diagnosis
			  • differential diagnosis
			  • assessments
			  • presentation section
			  • CDA implementationathon
			  • Essential Information for Children with Special Healthcare Needs (Mike Padula)
			  • Others
			  • NCPDP/HL7 Pharmacist Care Plan - Shelly Spiro
			  • ELIDS
			  • Nutrition
			  • **Patient Care Care Plan 2.0 Project**
			  • Model/FHIR Harmonization - Laura Heermann/Emma Jones
			  • Gaps in Care
				PC	Laura/Stephen /Michael T	Accepted: Pharm, LHS, SD

Thurs Q1b			Common Topics (Stephen will ask Eric/Rob what this is and PC rep needed)	OO	Not Applicable (Rob H)	CDS, Templates **PC did not respond**
Thurs Q2	Baltimore	25	Template update Updates on CCDA to FHIR Update on use of StructuredDefinition to represent CDA Templates **Stewardship of clinical content (Need hearty representation from SDWG)** **Clinical Status (Need hearty representation from SDWG)** GF#14874 Condition statuses	PC	Stephen/Laura (Michelle attend)	Accepted: SD, Templates
Thurs Q2			EHR - Hot Topic Reducing Clinician Burden		Emma?/ Laura?	

Thurs Lunch	Frederick	10	Co-Chair Admin (plan next WGM agenda) DMP Review - slight changes made Final V2 ballot comments	PC	Michelle /Michelle	N/A
Thurs Q3a			Clinical Statement (currently in maint state and does not require further discussion until PC is notified)	CS	Not Applicable	OO Declined: PC
Thurs Q3b	Constellation E	35	FHIR Trackers (AdverseEvent) • PC proposes a new FHIR resource - Adverse Reaction that is referenced by AdverseEvent and AllergyIntolerance • GF#18854 SuspectedEntity doesn't work for "certain" - STU #203 2018-Sep Core STU • GF#18853 The short description is significantly different in meaning to the Definition. - STU #202 2018-Sep Core STU • GF#18852 AdverseEvent.resultingCondition - inadequate and inappropriate for documenting adverse reactions associated with AdverseEvent incidents - STU #201 2018-Sep Core STU • GF#17397 Add ameliorating actions in AdverseEvent • GF#17238 Add attribute to capture future strategies/recommendations • GF#17237 Request to add attribute for actions or circumstances that prevented harm • GF#16092 Add contributing factors to AdverseEvent • GF#16038 Add interventions required in AdverseEvent • GF#16037 Add attribute to capture likelihood of recurrence • GF#16028 Add who detected the adverse event • GF#15573 AdverseEvent.category may need to be expanded • GF#13698 AdverseEvent.suspectedEntity.instance should allow CodeableConcept • GF#11021 Increase cardinality of substance and make certainty relation to substance not reaction - 2016-09 core #40	PC	Michelle /Michelle	Accepted: BRR
Thurs Q4	Constellation C		CareTeam DAM Ballot comments IHE Care Team Managment Profile Proposal- EJ	LHS	Not Applicable (Michelle /Emma/Laura attend)	Accepted: PC
Friday			Clinicians on FHIR (Russ will reserve room)			

Minutes

Mon Lunch

FHIR Committer discussion about a tooling change from SVN to Git.

Get Started with FHIR on GitHub

Using TortoiseGit with FHIR

Mon Q3a: with EHR

- Joint meeting with EHRWG hosting (mega joint).
  - Reported on PCWG projects (as per slide deck)
  - EHRWG indicated that it will initiate a project on School Children health information needs
  - Meeting this week: Thursday Q3 and Q4. Any PCWG member interested and able to attend please do
  - EHRWG will include PCWG and LHS in future email notification regarding progress on this project
  - PCWG: to consider participating as co-sponsor?
  - Here are the Mega Report out slides.

Mon Q3b

- Patient Care Admin
  - Not enough co-chairs to manage assignments; confirm in Q4
  - Ditto DMP: postpone to Thursday Lunch
  - Voted on V2 chapter 11 & 12 comments
- V2.9 ballots:
  - 222 Hans Buitendijk: In PID and OBR some fields about roles were deprecated and moved to PRD. Hans is augmenting that these fields were deprecated were for. Hans is willing to withdraw, because PRD now are taking care of these roles.
  - 223- 227 and 229 Hans argues that backwards compatibility must be assured. The participation in the OBR is now part of choice box. The choice should not be on the inside, but on the outside. The Choice bar has to be removed. Vote 5. 0. 1
  - 228 RXA. Brackets should disappear around RXA, but Amit says that is was left unchanged. It is already on the line above. Nee d to check with pharmacy as well. Motion to remove the brackets by Hans. Daniel Second. Vote 5 .0. 1
  - Chapter 12 PID. There are no roles in chapter 12. It is not consistent in this chapter. This chapter was not dealt with. PRT should be added. Where role appears should be substituted with PRT. Proposal 716. Vote 5.0.1
  - Note (about deprecation) in chapter 12.4 is a left over from previous publications. Remove this text from the publication. Vote 6.0.0
  - Comment from Ricki. Does PRT and PRD cover all functionality that where deprecated by role. Amit has to perform this analysis and will come back. Amit would like to come back to PC this week. During co-chair lunch.
  - 442 is duplicate of 267
  - 443 is persuasive Apply the CR851 to chapter 12. Vote 6.0.1
  - 444 is more an editorial reference in Definition should not be explained but a reference to a separate table. also apply CR 851 Vote 6.0.1

        - 445 Is about a negation indicator. If value is set to yes, then it means that the negation is true and means that a relationship does not exist. The definition should be rephrased to: This field asserts the absence of the relationship. Persuasive . Vote 7.0.0
- PSS suggestion from Jay: Proposal to merge the 2 DAMS of Immunization and allergies. The DAMS overlap in classes. Risk that you open a can of worms. Purpose is to find common ground in the classes and clarify the functional needs. The UML could be used to generate specifications.. The timeline for the paper is January 2019. This PSS needs to be discussed with PHER as well. Could raise questions on what the consequences are for FHIR resources. On the other hand the FHIR development team is working on workflow patterns which could also influence the FHIR resources and partly doing the same as the DAM. Motioned moved by Jay to co-sponsor and perform the work on the DAMS. Amit second: Vote 3 .0..2.

Mon Q4: OO/PC Joint Meeting

OO hosted the quarter with PC joining

GF#17576 Observation.comment cardinality

GF#17359 Task and Procedure resources completely overlap - need clarifying descriptions (this is the PC tracker for Procedure) – will vote when PC is hosting
GF#19109 Task and Procedure need clarifying boundary descriptions (this is the OO tracker for Task) – resolved since OO was hosting

Tues Q1: CIMI Wound demonstration project

Received many different comments. There were comments it was difficult to read. Other comments fell into:

- Review of ballot comments on Wound proof of concept
    - timing and presentation (28. 63)
    - Objectives
        - Tool demonstration
        - Pattern demonstration/proposal
        - requirements validation
    - Approach (61, 80)
    - Other priorities (total of 130ish comments out there - unclear on the priorities of these)

Detailed notes re: the reconciliation of each ballot item included in the ballot docs.

To do: need to take the process part of CIMI ballot process to the CIC/CIIC discussion.

#28

Motion made: Mark this item as non-persuasive with MOD. To work with the sponsoring WG and the relevant steering divisions to publish ballots according to the HL7 publishing calendar in a publicly visible calendar to accommodate community and WG reviews with response times to accommodate updates and changes in the ballot documents prior to publishing for ballot. This will keep in mind the type of ballot being pursued - acknowledging the point and purpose of "for comment" ballots to get broad review of innovative thinking.

In addition - to the second point of the comment - This was an experiment asking for feedback which was not clear to the readers. Going forward we will be clear on what is consistent with the last balloted version of CIMI and what are new concepts and beyond the last balloted version CIMI.

Motion by LKHL

2nd by MK

Abstains = 0, oppose = 0, approve 25.

#63

Discussion: Persuasive with mod: Thank you for your comment – will take this into consideration for future publications.

Motion made by LKHL

2nd by RE

Abstains = 0, oppose = 0, approve 25.

#61

Persuasive with mod – it depends on the context. Requirements may be implicit in some assests in some cases In others they may need to be modeled.

Ran of time – will take this to PC and/or CIMI calls for completion of all the other ballot comments.

Tues Q2: PC+ SD clinical notes

Chair: Michelle Miller
Scribe: Michelle Miller

Clinical Notes - Presentation slides from Brett, who led Connectathon Clinical Notes track this past weekend

The recent focus (including Connectathon) was the introduction of DiagnosticReport when Lab Reports, Radiology Reports, and Cardiology Reports were added to the scope.

David Hay asked if a custom operation was considered? He used the example of a HAPI server writing a DiagnosticReport, which doesn't, by default, mean that it will be accessible as a DocumentReference. Similarly, if a DocumentReference is written, then ontology would need to be used to infer it is also a DiagnosticReport.

Why not replace DiagnosticReport.presentedForm (Attachment) with a Reference(DocumentReference)? DocumentReference doesn't add any additional value that Attachment doesn't have.

Next Steps / Decisions

1. Create an international profile for clinical notes (which may not use the LOINCs that US / Argonaut used)
2. Log Trackers to clearly acknowledge in the specification that the boundaries are not clear (between DiagnosticReport and DocumentReference) in the sense that there is overlapping content that could be in either resource (e.g. "the green area" in the Venn diagram in the ppt linked)
    a. DiagnosticReport (GF#19249) boundaries -- OO
    b. DocumentReference (GF#19250) boundaries -- SD
    c. Clinical Safety Checklist (GF#19251) -- FHIR-I
3. When adding guidance in the spec about clinical notes, whether ALL servers need to be expose Binary as both DocumentReference and DiagnosticReport will be optional in base spec and IGs can make required as needed
4. Custom operation to query both resources
5. Log trackers for OO to consider increasing cardinality of both DiagnosticReport.code (procedures done, such as head and neck) and DiagnositicReport.category (such as interventional radiology and radiology) - include link to PPT with LOINC parts
    a. DiagnosticReport.category - GF#19252
    b. DiagnosticReport.code for procedure - GF#19253

Regarding January Connectathon, we would like to have more clients since past Connectathons have had servers only

Evelyn Gallego - Introduction to CMS Electronic of Medical Documentation Interoperability (EMDI) Initiative

- Focused on document exchange between providers and providers (focused on hospitals and post-acute providers)
- Led by CMS and sponsored by CMS
- Reuse standards
- Digital signatures involved
- No IG plans at the moment, but do have EMDI Pilots
- Will share more on pilots in January

Consultant Pharmacists using consult notes embedded with SNOMED codes for exchange of MRR (medication regimen review - federal requirement by CMS) exchange with physicians monthly to meet CMS federal requirements. NCPDP formed a task group under work group 14 to write a guidance document using the consult note for this purpose. Information can be found on the NCPDP collaborative website dms.ncpdp.org under WG 14.

Tues Q3: FHIR

FHIR Ballot Prep (source of truth)

- Oct 31: All R4 STU comments reconciled in gForge with votes and no " tracker issues"
- Nov 1: Substantive change freeze for R4
- Nov 11: Final content freeze, start of QA
- Nov 25: QA finishes, start apply QA
- Dec 2: Specification locked – no commits without permission

Priorities:

- FHIR R4 STU ballot reconciliation
- Documenting FMM Evidence
- IG ballot reconciliation
- Plans/priorities for R5

Follow-up / tracker issues

- GF#17359 Task and Procedure resources completely overlap - need clarifying descriptions (this is the PC tracker for Procedure)
    - GF#19109 Task and Procedure need clarifying boundary descriptions (this is the OO tracker for Task) – resolved in Mon Q4 during joint OO/PC
- GF#16190 - prior motion (to find tracker persuasive) was defeated, but gForge requires a second motion (to find tracker not persuasive) in order to have a successful vote 2018-May Core STU

CommunicationRequest - Victor asked his question in Tues Q2 instead

Goal-related tracker

- GF#17756 Consider whether Goal.status should be split into 2 elements 2018-Sep Core STU

Tues Q4a: Vocabulary. Negation, Condition Status, harmonization, binding strength

Gaps in Care - Overview provided

- Gaps in Care project by CQI
- Addressed in population management
- Care Plan perspective - from the patient level. Looking at what is being done in the population so it can be incorporate in the patient level. Related but
- Synching with KP Sethi. John D'More from Diameter health is also working on thie need to add him to the agenda

CQI requested procedure/QDM discussion

- identify if a procedure has been adequately done - outcome resource doesn't seem to be adequate.

Negation

No Known

- Ongoing work
- Have been doing transforms to get from C_CDA to FHIR - taking a bottom up approach
- Link in the presentation to the WIKI - see negation transformation link. NKA - need to get answer from folks. How do we get agreement from the specifiers about what this means and when are they equivalent. Who do we get agreement from.
    1. Do these things really mean the same thing - need people to agree it does before progressing
    2. Spec owners need to use this to confirm
- Discussion about modeling know known and I don't know.
- Implementers are exposing the NKA for two different standards. In that case, they are equivalent
- Suggest taking a step back and see what patterns have little nuances.
- Do clinical decision support need to take this into consideration? CDS need to base their rules on what the clinician would decide.
- Right side will not go into the specifics - e.g. no known peanuts allergy
- Getting to the specifics will require SME
- Suggest removing row 4 out of the list (status) and leave this strictly to the allergy
- Noted there is an error in the next tab - NKASpecific. Think this should be refuted as the status code.
- Will have a batch of these in the ballot in Jan.

Statuses and Negation

- What do status have to do negation
- Clinical status and Verification statuses
- Where in current clinical documentation does active, inactive then remission? what does confirm mean in the real world?
    - This applies to chronic conditions - verification statuses are valid for clinical use.
    - A lot of this is in clinical notes. Working diagnosis has clinical use.
    - Advanced decision support analysis can use this to determine way to managing and modeling this.
    - Agree with modeling this but changes in the real world does not happen.
    - How are quality measures defined? If they have a condition and it's in remission - are the quality measures looking for the remission or just that they have the condition
        - QDM used to have active, inactive remission. Current eCQM uses effective time.
    - These statuses are taken into consideration with reconciliation (active/inactive)
- A lot of the problems are due to human laziness - if humans will get away with not documenting the status then they will not do it.
- There is clinical judgement - people leave things as active as clinical judgement because they know it will come back.
- Inactive and refuted is not a double negative - can make a clinical judgement where something marked as inactive can refute the inactive and make it back active.
- Allergy clinical status (Wed Q1) and Thurs Q2 discussion with SDWG about statuses. No longer having Wed 5pm status calls

Procedure Status - use for quality measures

- completed colonscopy whose procedure was not done correctly was falling out of the measure results.
- There is procedure.outcome but it's awkward to use as is. Suggesting procedure.outcome be better defined.
- Suggestion
    - Need another element called outcome with binding to clinical findings
    - Need a second element for adequacy that will bind to the existing outcome binding or bind to adequate/inadequate/partially adequate - Floyd logged a tracker See 17946 Tracker
- Don't think adding an element of adequacy will work because that is subjective. Need to be more definitive.
- Success and not success is just as subjective.
- Idea for adequate/inadequate is for when the procedure did no solve the objective of the procedure.
- Trying to decide status without specific use cases. Clinical status may not be the right thing. May need to use disease state. Suggest taking a different look at this.
    - We have a use case that is following up on people who missed something getting done.
    - The issue may be using a specific use case on a general structure
    - there have been infinite number of use cases - disease state vs clinical status is a matter of synonyms.
    - This justify a profile.
        - Profile has impact at the instance the resource is created. If the data isn't there at the point of collection will lead to not having what is needed later.

- This shouldn't be driven by quality measure - will be a matter of the tale wagging the dog.

GF#17946 Confusion regarding 'status' and 'outcome' metadata elements of "Procedure" resource In Person Floyd

Tues Q4b

Wed Q1

Chair: Michelle Miller
Scribe: Michelle Miller

Condition

- GF#18833 Remove clinicalStatus requirement constraint - STU #31 2018-Sep Core STU (in person - Corey Spears) - resolved
- GF#18832 Add more clarity to Condition.category - STU #30 2018-Sep Core STU - Corey said no additional changes were needed after we resolved GF#18833

Allergy

- GF#18819 Placeholder. There are some types that may be in issue - STU #17 2018-Sep Core STU Corey said we can withdraw / find his comment as no change needed due to it being submitted by mistake
- GF#18831 Remove clinicalStatus requirement constraint - STU #29 2018-Sep Core STU (in person - Corey Spears) - resolved (but not persuasive with mod)

Wed Q2a

PA/PC joint quarter, with PA hosting

GF#18825 Add a reference to Observation for Appointment.indication. - STU #23

GF#18828 (duplicate of GF#18825)

GF#18829 Make element naming and modeling more consistent for Appointment/Encounter reason - STU #27

LHS CareTeam DAM is being balloted.

PC needs to document requirements for CarePlan reviews before we meet with PA next to see if there are gaps in VerificationResult.

Wed Q2b

Wed Q3a

OO hosted quarter, with PC joining

GF#18838 Add support for instructional material - no vote (need more information from Emma) - discussion ranged from having CommunicationRequest. basedOn reference the ServiceRequest; using CommunicationRequest.payload.content (since that can be a string, Attachment, or Reference to any)

GF#15726 add unit and total cost to ServiceRequest

Wed Q3b

OO meeting: blood Products, tissue and biological product (update needed)

There appears to be not much progress on this topic

To follow up with OO in future

Wed Q4

FamilyMemberHistory

- GF#18848 ValueSet for BirthSex (i.e.Clinical Sex) should be XX|XY|other (e.g. XXY, XYY) rather than gender (male/female) - STU #193 2018-Sep Core STU
- GF#18850 FamilyMemberHistory.gender should be mapped to AdminitrativeGender valueset, not BirthSex valueset - STU #195 2018-Sep Core STU
- GF#17780 Change Family History gender attribute to be consistent with definition

Thurs Q1a

Todd Cooper moved that PC be primary sponsor of Dental Interoperability Investigative Project for January. Jim McClay seconds. Motion carries 23-0-0

Mike Padula reported on Children with special needs. We have use cases modeled in CDA and FHIR. They address several topics including contingency plans. There is a grant request from HHS: tech solutions for care coordination for children with special needs. This may affect scope to support parental participation.

Shelly Spiro reported on Pharmacist care plan. The guide balloted (for comment) in September has been widely adopted. Adoption has been wide in the Community pharmacy enhanced network. Innovation center has publicized nationwide. Shelly had examples of content, but these cannot be shared publicly at this time. The specification has not been published; the team plans to address comments from last year and reballot in May 2019 as DSTU.

Structure Documents requested to address Provenance in Q2.

ELIDS report. Informative document on information requirements balloted; moving toward balloting an IG.

Margaret Ditloff reported on Nutrition. Guide is published, looking for implementers. Need to update dietetics terminology updates.

CDA Management group

Working on changing implementationathons to support ability to identify topics or questions for implementers to address.

Working on scheduling implementationathons simultaneously with FHIR connectathon

Planning joint meeting with Commonwell meeting in April

A project to enhance and harmonize CDA. Prior iteration focused on allergy & concern in CCDA; keeping clinical scope but expanding to include all CDA, viz., International Patient Summary. [and FHIR?]

Question: how do we (SD, PC) work together?

Objectives seem to be a) improve CDA, b) provide mapping & transformation guidance (non-normative but advocated by workgroups), and c) work out how to coordinate this kind of thing.

PC expressed concern over time constraints. We will discuss how PC may be able to accommodate this effort.

Public Health

National healthcare survey template has Primary diagnosis. It's a problem observation with Code: principle diagnosis (LOINC). Question: use priority preference template instead of code? High normal delayed priority. We don't think so. But Principle is a billing value after the fact. Instead ask LOINC what' s the right code. Change the code and reballot. (Whether this can be a revised template or a future one remains to be seen.)

Differential diagnosis also based on Problem Observation Code = diagnosis. Qualifier typeOfDiag=differential diagnosis. Actually a modifier.

These are working issues rather than status. We'll schedule time on a call to discuss in more detail.

Need guidance on Gender: another topic for the call

Assessments. : another topic for the call

Care plan DAM 2.0.

Working out scope, e.g., how to represent allergies relationships to Orders., gaps in care, self care, advance directives, care team, reconciliation, health concern, harmonization FHIM FHIR CCDA, and other topics. See page in Confluence.

Meetings Wednesday pm.

Additional notes from GD

Agenda

Into

Patient care has been working with Care plan dam. Patient care and learning health system. Ballot reconciliation beginning. – Will carry forward Tuesday evening.

Template update

Summary: This is being pushed to 2019, it will be placed on the list for San Antonio. Brett will send a link to documentation when available

Updates on CCDA to FHIR

Summary: Existing work is documentation on documents types for transform. FHIR documentation on what US Core profiles can be used. This material has not been recently updated. The Divinci project will be concentrating on CDA to FHIR and updates are expected over the next few months. Divinci group will be working on mapping CDA to FHIR. Historical project information can be found on Structured Document Wiki – Lisa Nelson to provide link.

Update on use of StructuredDefinition to represent CDA Templates

- Deferred

Stewardship of clinical content (Need hearty representation from SDWG)

- Deferred

Clinical Status (Need hearty representation from SDWG)

GF#14874 Condition statuses

- Deferred

Provenance (added to agenda)

Summary: Provenance appears as potential US regulatory criteria. Government wants industry to define, industry wants government to define, stalemate. This session was treated as discussion/discovery with input on vendor's current implementation, ONC's general need, and existing specification. Discussed use cases covering authors, assemblers, scoping options. Document specific data and data specific information. Outcome: An informational guidance document will be generated to cover CDA/FHIR. Assumption, it will be balloted. Timeline and owners to be determined. Proposed Principle Structured Document and Co-sponsor FHIRI. Brett will inform on final decisions.

Discussion Bullets

- There is an existing published. guidance document, is outdated and doesn't meet quality criteria
- Industry asking for guidance on US Core Data and providence, we don't know if they will become official.
- Government is signaling we need to take on providence.
- Industry doesn't want to make a move until government tell us what we need to do.
- Where is the best place to start? Group discussion on where to start to initiate
    - Old standards committee QI Core has old guidance.
    - There needs to be FHIR consistency, noted that FHIR provenance is not what the EHRs are doing.
    - Vendors
        - A: Decided FHIR provenance is not appropriate. Decided needed to know where the data came from. Organization, transmitter and organization of data creator.
            - Real issue is where did it originate and did it change.
        - B: Tracking provenance of the document not the data.
            - Who, where, time – (ONC) Play the paper form.
        - Becomes too cumbersome to track all the along the away document/data hops.
    - Need to separate the data from the document. =Audit – goes down to the data level.
    - Use case/- traceability of the data. Don't care about the number of hops Can you trace back to the originals?
    - CDA – Author and author time stamp. You have performer. (Suggest you need who gave it to you.
    - Use case, is not just the provenance – it the reconciliation, need to know what the right dose in, how much meta data – what is too much meta data?.
        - C: if you reconcile – it becomes new data, old one goes away. The original is still there if you retain the document.
    - ONC Comment- CDA and FHIR may need separate guidance. FHIR what is primary data and what is provenance resource.
    - Related documents, being used relative to the data?
    - Have you considered the custodian?
    - Authoring device – use case, EHR gets a request and auto generates a document. No human author (notion of an assembler) Its often noted as a participant – but an author is needed. Author is the "assembling device"
        - If CDA in the case of assembler- put assembler as author and participant. The organization becomes/should be the organization, its important to know that its assembled
- Who sent, who authored, time stamp. (CDA Doc) author of the document is the author of the data unless otherwise specified (performer).
    - Data level in the data author (performer)
    - FHIR has recorder – it would be CDA author,

Thurs Q1b

No response from OO regarding topic of interest to PC.

OO and PC already have multiple joint meetings throughout the WGM week discussing multiple topics of common interest

There is no need to continue this separate meeting stream in future

Thurs Q2

Joint session with SD, PC & templates

- No representatives from the templates group. No update templates.
- CCDA to FHIR. There will be FHIR activity at SD the coming periode and SD expect to be able to report at the next WGM in San Antonio.
- Lisa Nelson has a CCDA to FHIR implementation guide. This is based on STU v2. Da Vinci project will update to STU v4, but this is still in progress. The information on SD can be found on a HL7 Wiki, but it has not been updated lately.
- Brett gives an update on Data Provenance. The US government has not set the requirements and expect that HL7 would come with that answer. An organization should be in the provenance. The minimum requirements are the organizations from the sender and the receiver. Thom Khun mentions that the use case is to correct an error at the source. An example that Michelle Miller provides is an immunization where the vaccine is taken at a Walgreens. The actual originator is the PCP. Floyd argues that the source is the Walgreens.
- Comparison with paper flow. The PCP would fax the prescription and you would see in the header on the fax. How would do it in CCDA?
- You walk the chain backwards to find the original author. If you modify the data, then you become the new author. This is not traceable.

- With the example of immunization Lisa questions whether you overwrite the original data or add new data next to the old data.
- CCDA also has features within a CDA. There are author's with timestamps available.

- The provenance is used for reconciliation purposes.
- In CDA you always have an author, but FHIR could be generated by a system without a specific responsible person. In CDA an assembler is added as participant.
- If data is assembled by a system, then the organization is held responsible for the data.
- If a doctor signs off a system generated document, then he would be the author. Rob McClure would consider that as new document with a new author.
- The performer in CDA is the performer of the procedure.
- In the CCDA the consumer can modify the data and therefore is the person responsible for the data.
- An informative paper will be set up and go to ballot. Lisa is thinking about cross paradigm document about principals. A PSS Is required. **Action Brett Marquard.** SD would be prime sponsor and FHIR-I as co-sponsor.

Thurs Lunch

Chair: Michelle Miller
Scribe: Michelle Miller

v2 ballot reconciliation - votes captured in the ballot reconciliation spreadsheet (Amit)

DMP - updates pertaining to Electronic Voting and announcements via EventMobi app. PC wants to keep the existing deviations, within Chapter 5 (quorum variances) and Chapter 7 (electronic voting variances). Discussion about quorum requirements for electronic voting. Motion by Laura /Stephen: quorum for electronic voting is 7 members, where at least 3 of which are co-chairs. Vote: 8 approve - 0 against -0 abstain

Thurs Q3a

Thurs Q3b

Adverse Event

Chair: Stephen Chu
Scribe: Emma Jones

FHIR resource PC inherited from BR&R

Overview provided.

- Scope - Clinical documentation support; reporting adverse incidents and QA within an organization; regulatory agencies related to clinical trials
- Is adverse events that is the result of a treatment - such as an adverse reation to immunizations where you may or may not know something bad will happen included in the scope?
    - This is included in the scope. Even if a medical event did not occur but there was a deviation from the correct clinical practice, this is included in the scope.
- Vocabulary specifications for this area - e.g. ICH vocab. Is this included?
- recording a bad thing that happens to the patient should use one resource and recording things to do to prevent it happening in the future (what to do next) should be another resource. PC have been asking for an adverse reaction resource that can be used for allergy reaction - suggest calling the thing the happened "Adverse Reaction" and the thing that is the result of the adversity "reportable event"
- Suggest separating into 'reportable event' and 'reaction'
- A fall can be an incident/event - need to be able to capture cause or contributing factor
- ICSR - generic reporting for medication safety.
    - Initial reporting can be simple. Europe has the yellow form/yellow page/yellow card - requirements is very broad. Point is the scoping is important. Need to ensure what ever we come up with has requirements that will work for applicable situations.
- Given the expanded scope we want to entertain, is it okay to create an adverse reaction resource?
    - Need to determine the direction to go
    - Need to try some actions as examples/use cases
    - Both PC and CIMI have contributed to
- Discussion about the terms used to describe the event and the reaction to the event. It doesn't matter what to call it, just provide a handle that we can hang onto. "reaction" seems to be pre-judging.
- Use of observation or condition is generic - if querying for observation or condition, will get back things of which you may not know the context. Need something that is can be used as a bucket for things that contains unforeseen things that may happen to a patient. It's
- Patient have a temp of 103, can document a condition - febrile. Is it something to worry about? there is a judgement or policy that can be classified as an incident. Some judgement level that can escalate to something that can be reported, documented, etc. There is a whole chain of events that can occur after.
- Consensus for creating this "thing".
- Adverse event as is have a lot of reporting elements can be used for the reporting piece.
- Patient given a dose of drug and the patient goes into shock - is that an adverse event or a reaction?
    - if you know the med will cause an anticipated 'event' i.e. a known side effect - call that an observation/condition because it's expected.
- Want the bucket to know ahead of time if you need to report events - in cases where there are not clinical trials - to be able to report to the hospital quality of care committees.
- How do you decide, when to you decide to use the bucket? Ho do you determine the things that goes in the allergy intolerance bucket?
- Joint Commission Incident reporting is all over this - document the patient fall, then seperately document if there was water on the floor, etc. - this is about the same thing
- they all go in the same bucket but the process of where they end up may differ. Start with the escalation judgement that something is written down in a special way that is later categorized and handle differently further down.
- Sounds like the bucket can have lots of things - observations, conditions, judgement call - like a staging area.
- Issue is can't call it condition, observation because need a clean way to query.
- Partial agreement with incident - because when a fall it works fine. But when given a drug
- Suggest providing multiple categories to define the incident - can be security and physical related issue; suspected reactions; reactions
- Suggest bucket to be created; include categories

- Will re-look at the adverseEvent resource and point it to the bucket. Same way reaction piece will come out of allergyIntolerance and point to the bucket
- **Hugh moved that a new resource to be created, named "Incident" with a catgeoty element to differentiane incident like falls, advers reaction, etc.**
    - **Ben second.**
    - **No further discussion**
    - **1 abstain; 0 oppose; 21 for**
    - **Patient will own creating the resource proposal. Ask for everyone to please assist.**
    - **Action: Invite to the BR&R list. Will also include pharmacy**
- Quarter adjourned.

Thurs Q4

FHIR Tracker Backlog

AdverseEvent

- GF#18854 SuspectedEntity doesn't work for "certain" - STU #203 2018-Sep Core STU (Thurs Q3)
- GF#18853 The short description is significantly different in meaning to the Definition. - STU #202 2018-Sep Core STU (Thurs Q3)
- GF#18852 AdverseEvent.resultingCondition - inadequate and inappropriate for documenting adverse reactions associated with AdverseEvent incidents - STU #201 2018-Sep Core STU (Thurs Q3)
- GF#17397 Add ameliorating actions in AdverseEvent
- GF#17238 Add attribute to capture future strategies/recommendations
- GF#17237 Request to add attribute for actions or circumstances that prevented harm
- GF#16092 Add contributing factors to AdverseEvent
- GF#16038 Add interventions required in AdverseEvent
- GF#16037 Add attribute to capture likelihood of recurrence
- GF#16028 Add who detected the adverse event
- GF#15573 AdverseEvent.category may need to be expanded
- GF#15028 Update cardinality of identifier elements
- GF#13698 AdverseEvent.suspectedEntity.instance should allow CodeableConcept
- GF#11021 Increase cardinality of substance and make certainty relation to substance not reaction - 2016-09 core #40

CarePlan

- GF#13903 CarePlan should allow tracking of past activities (i.e. past interventions)
- GF#13140 logical definition of care-plan-category value set may require realignment with SCT changes
- GF#11173 CarePlan needs support for reviews - 2016-09 core #327 – Deferred
- GF#10028 Careplan: Provide ability to specify patient and/or provider preferences

Goal

- GF#17755 Add support for conveying whether the goal is a one-time goal or an on-going goal 2018-Sep Core STU (Tues Q3)
- GF#17756 Consider whether Goal.status should be split into 2 elements 2018-Sep Core STU (Tues Q3)

AllergyIntolerance

- GF#17592 FHIRPath expression of search parameter "onset" on AllergyIntolerance is wrong
- GF#17743 Change AllergyIntilerance "clinicalStatus" and "verficationStatus" to "CodeableConcept" and consistent with Condition 2018-Sep Core STU (in person - Ioana Singureanu)
- GF#17810 Add abatement in AllergyIntolerance
- GF#17830 Change the description of recordedDate to match the definition
- GF#17886 Invariants in AllergyIntolerance have errors (alt-1 and alt-2)
- GF#18819 Placeholder. There are some types that may be in issue - STU #17 2018-Sep Core STU (WedQ1)
- GF#18831 Remove clinicalStatus requirement constraint - STU #29 2018-Sep Core STU (Wed Q1 - in person - Corey Spears)

SD / SOAP Notes

- GF#12676 Guidance request for GP SOAP in FHIR
- GF#14720 Add Guidance for Exchanging Notes - 2018-Jan Core #42

CommunicationRequest / Communication

- GF#17902 Description for Communication resource may need to be updated
- GF#13936 CommunicationRequest - intent value set

Condition

- GF#18833 Remove clinicalStatus requirement constraint - STU #31 2018-Sep Core STU (Wed Q1 - in person - Corey Spears)
- GF#18832 Add more clarity to Condition.category - STU #30 2018-Sep Core STU
- GF#17885 Invariants in Condition have errors (con-3, con-4 and con-5)
- GF#17736 Need guidance on representation of Concern
- GF#17667 Allow Condition.recorder to be PractitionerRole
- GF#17445 Incorrect ECL expression syntax in condition mapping
- GF#16147 Condition.category - can be used to specify granular type code? 2018-May Core - In Person – Deferred
- GF#14874 Condition.clinicalStatus should not be a limited to a code from the condition-code value set - 2018-Jan Core #215-InPerson – Deferred

- GF#14872 Not sufficient support for Concern - 2018-Jan Core #213 – Deferred

FamilyMemberHistory

- GF#17682 clarify no family history text
- GF#17780 Change Family History gender attribute to be consistent with definition (likely mark as Duplicate)
- GF#17808 Add support for Procedure in FamilyMemberHistory
- GF#17809 Add condition abatement in FamilyMemberHistory
- GF#17887 Need negative examples for family history
- GF#18848 ValueSet for BirthSex (i.e.Clinical Sex) should be XX|XY|other (e.g. XXY, XYY) rather than gender (male/female) - STU #193 2018-Sep Core STU
- GF#18849 BirthSex may be more appropriately modelled under Observation - STU #194 2018-Sep Core STU
- GF#18850 FamilyMemberHistory.gender should be mapped to AdminitrativeGender valueset, not BirthSex valueset - STU #195 2018-Sep Core STU
- GF#18855 What's reason for age of family member - STU #204 2018-Sep Core STU
- GF#18856 What's reason for deceasedDate of family member - STU #205 2018-Sep Core STU
- GF#18857 Revamp FamilyMemberHistory.condition - STU #206 2018-Sep Core STU
- GF#18858 Change to be condition-centric - STU #207 2018-Sep Core STU

ClinicalImpression

- GF#18861 ClinicalImpression.assessor name is inconsistent - STU #210 2018-Sep Core STU
- GF#18860 Merge investigation and supportingInfo - STU #209 2018-Sep Core STU
- GF#18859 Definition/description at odds with what clinical impression is - STU #208 2018-Sep Core STU
- GF#10635 QA 5a: Resource references exist in both directions for Condition and ClinicalImpression - Deferred

Procedure

- GF#17946 Confusion regarding 'status' and 'outcome' metadata elements of "Procedure" resource In Person Floyd
- GF#17359 Task and Procedure resources completely overlap - need clarifying descriptions
- GF#13047 Add DosageInstructions to Procedure
- GF#12993 Please Create a NonMedicationAdministration object or an Administration object

8 Deferred ballot comments

- GF#10635 - Michelle Miller logged it and is ok deferring due to ClinicalImpression maturity
- GF#11021 - deferred previously - Allergy reaction (Jay)
- GF#11173 - Stephen Chu - deferred previously - CarePlan reviews
- GF#11332 - Acknowledge Advance Directives as type of Care Plan - 2016-09 core #490
- GF#14720 - Brett Marquard - joint discussion with SD at WGMs - notes
- GF#14872 - Mark Kramer - health concern
- GF#14874 - Condition.clinicalStatus should not be a limited to a code from the condition-code value set (Jay)
- GF#16147 - Claudo Nanjo - Condition.category - can be used to specify granular type code?

1 Waiting for Input (ballot-related)

- GF#11026 - 2016-Sept Core Ballot - Jay Lyle was thinking about how to decompose - Relationship between Condition and Observation