2022 May WGM Patient Care Agenda and Minutes

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  - Thursday Q2
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  - Thursday Q4

Attendance

2022 May WGM Patient Care Attendance - Patient Care

Quarter - Time Zones Conversions

<table>
<thead>
<tr>
<th>Quarter</th>
<th>USA (Eastern)</th>
<th>USA (Central)</th>
<th>USA (Pacific)</th>
<th>Central Europe</th>
<th>Australia (mel/syd)</th>
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<tbody>
<tr>
<td>Q1</td>
<td>9:00 - 10:30 AM</td>
<td>8:00 - 9:30 AM</td>
<td>6:00 - 7:30 AM</td>
<td>15:00 - 16:30</td>
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<td>Q2</td>
<td>11:00 - 12:30 PM</td>
<td>10:00 - 11:30 AM</td>
<td>8:00 - 9:30 AM</td>
<td>17:00 - 18:30</td>
<td>01:00 - 02:30 AM</td>
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<td>Q3</td>
<td>1:30 - 3:00 PM</td>
<td>12:30 - 2:00 PM</td>
<td>10:30 - 12:00 PM</td>
<td>19:30 - 21:00</td>
<td>03:30 - 05:00 AM</td>
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<td>Q4</td>
<td>3:30 - 5:00 PM</td>
<td>2:30 - 4:00 PM</td>
<td>12:30 - 2:00 PM</td>
<td>21:30 - 23:00</td>
<td>05:30 - 07:00 AM</td>
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<tr>
<td>Q5</td>
<td>5:30 - 7:30 PM</td>
<td>4:30 - 6:30 PM</td>
<td>2:30 - 4:30 PM</td>
<td>23:30 - 1:00</td>
<td>07:30 - 9:30 AM</td>
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Agenda

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Topic</th>
<th>Host</th>
<th>Chair</th>
<th>Scribe</th>
<th>Joining Work Groups / Notes</th>
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<tbody>
<tr>
<td>Mon, May 9</td>
<td>Q1</td>
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<tr>
<td></td>
<td>Q3</td>
<td>UNICOM</td>
<td>BRR</td>
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<td>Accepted: PC</td>
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<td></td>
<td>Q4</td>
<td>ADI on FHIR Report Out</td>
<td>PE</td>
<td></td>
<td></td>
<td>Accepted: PC</td>
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<thead>
<tr>
<th>Tues, May 10</th>
<th>Q1</th>
<th>PC/CIMI</th>
<th>PC</th>
<th>Jay</th>
<th>Accepted: CIMI</th>
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<tbody>
<tr>
<td>Q2</td>
<td>AdverseEvent</td>
<td>PC</td>
<td>Jay</td>
<td>Jay</td>
<td>Accepted: BRR</td>
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<tr>
<td>Q3</td>
<td>US Realm</td>
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<tr>
<td>Q4</td>
<td>Vocab/PC</td>
<td>PC</td>
<td>Jay</td>
<td>Emma</td>
<td>Accepted: CIMI, Vocab, CQI, HSS, OO</td>
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<td>Invited: PA, SD,</td>
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<tr>
<td>Q5</td>
<td>PACIO Birds of a Feather (Confirmed)</td>
<td>PACIO</td>
<td>Stephen</td>
<td></td>
<td>Confirmation Received from Dave Hill</td>
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<tr>
<td>Wed, May 11</td>
<td>Q1</td>
<td>OO owned FHIR resource topics (no invite received)</td>
<td>OO</td>
<td>PC (Emma Jones)</td>
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<tr>
<td>Q1</td>
<td>EHR WG Hosting HSS and PC WGs</td>
<td>EHR</td>
<td></td>
<td>Accepted: PC (Michelle Miller), HSS</td>
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<tr>
<td>Q2</td>
<td>*Provenance/Mapping questions - Main call</td>
<td>SDWG</td>
<td></td>
<td>*SDWG with CMG/Request for Michelle et al (from the PCWG author mapping FHIR discussions)</td>
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<tr>
<td>Q3</td>
<td>PA/PC Joint</td>
<td>PA</td>
<td>Stephen</td>
<td>Accepted: PC</td>
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<td>Q4</td>
<td>International Patient Summary (IPS)</td>
<td>PC</td>
<td>Rob H., Michelle Miller</td>
<td>Emma</td>
<td>Accepted: CGP, HSS, PE</td>
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<td>Thurs, May 12</td>
<td>Q1</td>
<td>CarePlan Report Out</td>
<td>PC</td>
<td>Laura</td>
<td>Emma</td>
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<td>Accepted: Pharm, CQI (reps only), HSS, PE, LHS, CIC</td>
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<td>Invited: SD, CDS, EC</td>
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<td>Q2</td>
<td>PC/SD/CDA-MG</td>
<td>PC</td>
<td>Jay</td>
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<td>Accepted: CDA-MG</td>
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<td>Invited: SD</td>
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<tr>
<td>Q3</td>
<td>LHS Virtuous Cycle Project - registries + quality improvement</td>
<td>LHS</td>
<td>Russ</td>
<td>Emma</td>
<td>Accepted: PC, CDS</td>
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<td>BRR, PH, CIC, CQI, CIMI</td>
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<td>Q4</td>
<td>Patient Centered Care Team DAM</td>
<td>LHS</td>
<td>Russ</td>
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<td>Pharm, PA, CIC, CQI, CIMI, HSS</td>
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### Minutes

**Tuesday Q1**
Updates on CIMI efforts

- skin & wound - Nathan to investigate publication tooling issue.
- podiatry - specializes skin & wound, by EHR. has not gone to ballot.
- vitals (1541) https://build.fhir.org/ig/HL7/cimi-vital-signs/: aiming for stu publication
- COVID 19 FHIR IG (1620) https://build.fhir.org/ig/HL7/fhir-COVID19Library-ig/index.html: voted to publish; to FMG next for informative publication

Model questions

Allergy discussion from January
- reaction should be an independent resource
  - or an observation profile
- It's a description of symptom; conclusion of cause is a different
  - Need to be able to call it a reaction without calling it AE/AI
  - include onset & exposure
- There is a difference between association & determination of AI. This is usually not noticed but may be. Nursing process, e.g.: rxn 1st, 'allergy' later

Solutions
- Rxn resource?
- Add AE to codeable Ref?
- Add response to Medication Admin?
- Observation as partOf Med Admin?
- Detected Issue?
  - Add to ClinOnFHIR workflow. Define use cases, test in tool. Laura to schedule. Tue 5 pm ET standing call.

Tuesday Q2

Hugh: Vulcan progressing well, planning to invest more in AE page https://confluence.hl7.org/display/VA/Catalog+of+AE+Gaps

Jean: publication for http://hl7.org/fhir/us/icsr-ae-reporting
  - some extensions in R4 IG, changes mostly already made to R5

Remaining Jira
- Status FHIR-36009, FHIR-34200
- Code FHIR-34318, FHIR-26436
- Observation FHIR-34316

Discussion of Code, role in respective use cases

Two-use-case situation continues to require extensive discussion, even when no action items result. Action item: try modifying language to clarify boundaries up front.

> 9.9: The resource does not represent the event, but the characterization or interpretation of an event.

> The first-class data is (typically) included by reference, not recorded in the AE resource, which represents judgment process metadata (that this is an AE, why this is an AE, etc.).

> Proposal to expand AE.code to codeableReference & use it to point to whatever the thing is that is judged to be adverse. All of those things (care provision acts, disorders, contributing factors) already have homes in the resource, but this would specify the one of concern.

Jean to draft answer to FHIR-26436
PC to schedule time on FHIR call (5pm ET Th) to address; BRR to be invited

Tuesday Q3

Tuesday Q4

Agenda

CDA Gender Harmony plan

"Consent to Treat" codes

Floyd: use of Procedure for breast feeding measure

CCDA-FHIR Questions/Proposals

1. RecordedDate
   a. FC Allergy & Condition: Leave recorded date unmapped because it's not always author date
   b. Do not conditionally populate effectiveTime

2. Recorder
   a. FC Allergy & Condition: Use Provenance.agent(s) for CDA author; use "ProvenanceAuthor" if possible
      i. include Recorder? deduplicate?
   b. CF Allergy & Condition:
      i. Put all authors in Provenance
      ii. if there is one ProvAuthor, or one latest ProvAuthor
         1. Put latest CDA ProvAuthor in FHIR Condition recorder
      iii. Otherwise,
         1. if there is one Author, or one latest Author
2. Otherwise,
   a. don't

Discussion:

CDA Gender Harmony plan

- Rob Hausam
- Informative document is done
- How to do this going forward in CCDA – Gay will work with Lloyd
- Should this be done during existing SD calls or use additional call
  - Additional work for this is done for V2
  - V2 management group – Craig did work off line
- Lorraine made request to be included in the loop

"Consent to Treat" codes - Corey Spears

- PACIO Project working on the ADI IG
- Specifically addressing Healthcare Agent

Here is my Agent

Need to add what actions the HC Agent can take

Not talking about the procedure itself but metadata about the procedure


Mohammed – there is FHIR resources encapsulating more than just the code. The action is a codeableConcept. Suggest changing this in the Core Consent to a CodeableReference

Clarification of the requirement – patient is identifying individuals and specific procedures the agent can perform. Would like to identify a class of procedure and not individual procedures. Consent.provision.action – change to codeableReference

Rob M. what is consent for? The thing? When the patient exactly specifies what the proxy should be able to do.

Lorraine –

John M - Seems we are speaking to a "actor.role" and that "role" is mapped to a set of activities.

Floyd - What is the reason we can’t use the same consent for advance directive for the patient and use something like the requester to be patient or RelatedPerson - perhaps with an AuthorizedRelatedPerson profile? I.e., HealthcareAgent

Maria Moen – consent to allow someone to speak for you.

John Moehrke – nesting of provision allows you to do the same thing. The element to use is provision.provision. This element is used for the specific "procedure"

Jay – Cory’s question is about re-use of the existing vocab

Floyd – a certain person can decide

Emma – what are your functional use cases?

Corey – trying to identified the agent and the powers they need to perform

Lisa Nelson – have seen use case where the parent wants to prevent the children from removing them from their home.

Daver – agreement with Lisa there need to be a grouper

Maria – national jurisdictional definition. Saw an opportunity for an individual to expand on the basic jurisdictions. Majority of the forms are free text.

Davera – suggesting a grouper to be able to enumerate the coded concept.

John – thinks this has been done.

Jay – the need to predict what people would select.

Corey – there are particular areas of the procedure that aligned with MOLST. The point is to try to make this computable.

John – the datatype provides the free text possibility

Jay-did the environmental screen

Corey – This part of the IG is specifically for health care agents and what they can do.

Mohammed – suggestion to cover the delegation in the core
* Maria - It makes sense to match procedures authorized by the patient to the services delivered when we are talking about Portable Medical Orders. Not sure that level of specificity exists in the current forms that are patient-authored. I could be wrong and the forms are very diverse by jurisdiction.

* Ross - Agree re leveraging CDS in situations where directives are known, but have to remember that in many (if not all) jurisdictions written advanced directives can be overruled with verbal direction by patients or by delegates

* Paul - Do you need separate codes for request and reject? Does request=permit and reject=deny?

* Mohammed - suggest bringing this to the Consent working session with CBCP

* John – the current consent model has been almost 100% based on privacy consent. This is why the push back on using the action element.

Corey – Will be following up with John and Mohammed

Use of Procedure (Floyd)

* Floyd – Measure trying to identify that a new born in a hospital received only breast milk and nothing else. Ask if for baby to receive exclusive breast milk. Can provide nutritional intake for the product. What will be used to “administer” the breast milk.

* Becky Gradl – Nutrition Intake and Nutrition Product (pulled into R4B). NutritionProduct is in R4B.

* Yanyan – SNOMED code can be used. Have procedure codes.

* Jay – the neonatal registry had a similar

* Peter Jordan – provided the following 1163377005 Breast milk feeding management (Procedure); parent 440626008 Procedure related to breastfeeding; 1145307003 Exclusively breastfed (finding)

* Yanyan – looked at all feeding.

* Rob – look for it as a finding which will be an observation. Suspect that the mother is breastfeeding


Yanyan – this information is documented in the intake form. Would like ecqm to review the documentation – if so, the computer looks for any other dietary information.

* Paul Denning - PCNewborn."Single Live Term Newborn Encounter Ends During Measurement Period" QualifyingEncounter

  with 
  "[Substance, Administered": "Breast Milk"] BreastMilkFeeding

  such that Global."NormalizeInterval" (BreastMilkFeeding.relevantDatetime, BreastMilkFeeding.relevantPeriod ) starts during QualifyingEncounter.relevantPeriod

  without 
  "[Substance, Administered": "Dietary Intake Other than Breast Milk"] OtherFeeding

  such that Global."NormalizeInterval" (OtherFeeding.relevantDatetime, OtherFeeding.relevantPeriod ) starts during QualifyingEncounter.relevantPeriod

  

* Becky - would be nice if there was a nutritional administration resource.

* Floyd - Intended to be used only for inpatient.

* Becky - would doing this as an attestation work for now.

* Rob - could use a hack and treat is as a medication administration

* Stephen - How does FHIR deal with [fluid] Intake/Output charting? Would be nice to have intake and output.

* Becky - NutritionIntake included fluid, but again it is in R5

Provenance mapping

Provenance Domain

Jay - advertising for this discussion during SDWG Q2 quarter tomorrow.

Tuesday Q5 - PACIO - Birds of a feather

Presentation by Dave Hill on PACIO project progresses since the January 2022 WGM

Presentation (zip file) is here: 

* 2022-05-10 PACIO Birds of a Feather v3.pptx.zip

Wednesday Q4

CDeX Update - Eric Haas
• Added guide with draft content for Digital signature
• Direct Query Vs Task based approach

**Direct Query vs Task based Approach**

**Direct query**
- Synchronous
- Client (e.g., Payer) executes the basic FHIR RESTful search on the FHIR Server (e.g., Provider) to fetch patient data
- The FHIR Server (e.g., Provider) synchronously returns the patient data

**Task Base Approach**
- Asynchronous
- Client (e.g., Payer) creates a Task to request data and executes a basic FHIR RESTful create to POST it to the FHIR Server (e.g., Provider)
- The FHIR asynchronously fetches the data and updates the Task. When the Task is complete, the Data Consumer reads the document referenced by the Task.

**Clinical Data Exchange: Attachments for Claims and Prior Authorization**

1. Provider submits attachments + data elements for re-association
2. Payer accepts attachments
Clinical Data Exchange: Attachments for Claims and Prior Authorization

- Client (e.g., the Provider) invokes the 'process-attachment' operation on the FHIR Server (e.g., the Payer) to "PUSH" attachments data to Server
- "unsolicited" vs "solicited" business workflows for claims
- In addition to the attachment data, payload contains data for reassociation to the Claim/Prior Authorization

Other Features

Signatures

Purpose of Use (Task only)

Work Queue Hints (Task only)

Current State

- Structure Documents WG changed from "Co-Sponsor" to "Interested Party"
- CDex Version 1.0.0 published 3/28/2022
- CDex balloted in May 2022 ballot with focus on current Draft Content
  - Attachments transaction ("push" using a FHIR Operation)
  - Digital Signatures
- CDex at Connectathon 30
  - Minimal Testing
  - Reviewed RI, Testscripts (Still WIP)
Next steps - Ballot reconciliation

Meetings are on Wednesdays.

- Ballot Reconciliation
  - CDEEx Meeting every Wednesday:
    - https://confluence.hl7.org/display/TyP/CDEExMeeting
- Tentative New Draft Content
  - Claims and Pre-Authorization requests for Attachments
    - X12 277 and 278 FHIR Alternatives
- CMS Connectathon July 19 - 21 2022
- Publish Version 1.1.0 in Q4 2022
- Tentative Re-Ballot Draft content as Version 2.0.0 in September
  - Driver is this year’s legislative agenda for Attachments rule so guide needs to be in latest Ballot form before then

Drivers for the new draft is legislations.

New will be claims authorization attachments

Will get an X12 request and will send a FHIR response

X12 277 and 278 - SMEs are in the PIE WG
Discussion:

Isaac - Attachment rules - does Da Vinci have 3 burden reduction?

Eric - received this question as ballot comments. Need to get and provide clarity on this.

Isaac - there need to be four IGs to be supported by implementers.

Eric - lots of uncertainty in the attachment space

International Patient Access (IPA) (spec) (Isaac V.)

Discussion:

- Likelihood that servers will re-use its capability across countries
- Need to get time schedule with PCWG
- Hoping to get 5-10 min time slots weekly
- Seeing nice engagement and support
- Themes within the ballot feedback
- Trying to accurately reflect current state credibility of countries that are using and adopting FHIR.
- Inconsistencies - generally countries and jurisdiction don't define patient access profiles. Most countries will define national base profiles.
- Grahame - the must support focus is if this populated "behaviour". was not intended to require server support. For example patient identifier is must support. doesn't mean the server have to populate. Its about pulling apart the must support for patient safety purpose.
- John - guide in Vulcan based on IPS - how stable is IPS. Rob will give an update.
- Eric - if the must support is all client based that's good.
- Grahame - the server side must support is much looser. The IG have to address the Must Support. IPA is a different IG.
- Isaac - client must support is like clinical guidance; server side must support gives guidance to developers as a table of elements that are identified as more important that others. should be used with national level guidance.
- Grahame - patient.active - must support it if you need to get the record.
- Rob - sounds like there are different Must Support for client and servers.
- Isaac - engaging international FHIR community have been slight. Need to do outreach and education. Will focus this summer on improving the IG, getting thru the ballot. As a patient crosses border IPS shares the data between providers. For IPA, patients can access their data in what ever country they're in.
- John M - this client focused mustSupport is yet-another example of why mustSupport does not work as a Boolean. That said, the client "safety" items don't seem appropriate to be communicated in a profile, but would be better expressed as shall/should/may language on the client actor.
- Rob - IPA is closer aligned with US core. IPS is about a summary of relevant clinical data that is about crossing boundaries. Question with IPA is access to patient's data or patient access to data? IPA is a natural means of getting the data to create the summary.
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<tr>
<th></th>
<th>IPA (International Patient Access)</th>
<th>IPS (International Patient Summary)</th>
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<tbody>
<tr>
<td>Primary scope &amp; use case</td>
<td>• Patient access and app usage (often used within borders)</td>
<td>• Patient summary for “cross-border” care</td>
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<tr>
<td></td>
<td>• Key Recipient: Patient</td>
<td>• Implementation of ISO 27269 standard</td>
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<tr>
<td></td>
<td></td>
<td>• Key Recipient: Healthcare professional</td>
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<tr>
<td>Profile definitions</td>
<td>• Minimal based on what's generally available internationally</td>
<td>• Extensive based on what's expected as part of ISO 27269 standard</td>
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<td></td>
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<td>• Usage of Composition to create documents</td>
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<td>Terminology</td>
<td>• Minimal HL7 terminology bindings</td>
<td>• HL7 terminology bindings</td>
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<td></td>
<td>• Example bindings for clinical content</td>
<td>• Preferred/Required bindings including extensive use of SNOMED IPS Terminology</td>
</tr>
<tr>
<td></td>
<td>• No IPA developed terminologies</td>
<td>• Several IPS developed terminologies</td>
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<tr>
<td>Search &amp; generation</td>
<td>• API guidance included</td>
<td>• Minimal API guidance</td>
</tr>
<tr>
<td>API interactions</td>
<td>• Search requirements and recommendations defined by profile</td>
<td>• No search parameters included</td>
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<td></td>
<td>• $doc-ref operation defined</td>
<td>• $summary operation defined</td>
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<td>• SMART on FHIR interactions defined</td>
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<td>Human readable narrative (text)</td>
<td>• Optional within resources</td>
<td>• Optional within resources</td>
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<td>• Required for Composition resource (i.e. can be used to create viewable document)</td>
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<td></td>
<td>• Baseline for client applications</td>
<td>• Baseline for consumers of information</td>
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- January ballot
  - Ballot Dashboard
  - Scheduling for block-vote-2 (details on vote)
  - Recurring PC timeslot for upcoming votes?
  - Next PC call May 23, 2022 - ACTION: Emma will add to PCWG agenda.
- Argonaut sprint this summer
- Netherlands feedback about Must support

**International Patient Summary (IPS)**

**Discussion:**

- STU period is expiring in a few days. Need to get an STU extension. Very close to publishing and will get it out in the next 1-2 months.
- Have a number of pull requests getting ready to merge. Few publication cleanup.
- Have a longstanding set of link errors that show in the build but are not treated as errors. Can get around this by using manually generated text. Would like to see it fixed. John is working on this.
- Have gone through fairly good analysis for must support with a few countries - Canada, New Zealand. Most of the concerns have come up from the server side of things.
- Terminology updates - lots have happened in that space. SNOMED international has started offering a free set to terminology that is becoming available - out currently as a beta release. Will be available at the end of the year. Will have a full SNOMED international edition release. Can take the same definition for SNOMED non-member countries and expand it and get it dynamically updated. For publication will need to revise the valueset definition to accommodate this.
- Stephen - SNOMED edition for IPS - does the beta version include all the IPS concepts that has been defined.
- https://www.snomed.org/snomed-ct/Other-SNOMED-products/international-patient-summary-terminology
- To extend the STU - use a publication request in Confluence. Publication request created
- Motion: Jean Duteau moved to accept the IPS STU Extension Request as reviewed; Rob Hausam Second
- Vote: 0 Against; 0 Abstain; 22 For
- Georgio - CDA IPS IG will expire in Oct. Plan on doing an STU ballot in Jan. Need to do an STU Extension. Will join a PC call to get extension reviewed and discussed.

**Thursday Q1**

**Care Plan updates**

**MCC**
Pharmacist Care Plan - Shelly Spiro

Nutritional Quality Measures - Preview (Becky Gradi)
- Invitation from Dave Hill for Becky to present to PACIO

POLST - Diana Wright

POLST CDA IG Project page - POLST CDA IG

Project is a model of use - take a paper POLST form and make it into a CDA document. Its a clinician authored clinical form.

The language is very form specific.
National POLST would like to pilot it.
LOINC Process - can go to ballot with temporary but should not publish with temporary codes.
National POLST - POLST is not an acronym, its a term.

PaCP - CDA IG - Natasha
Personal Advanced Care Plan (PACP)

PACP dashboard: https://jira.hl7.org/secure/Dashboard.jspa?selectPageId=15201

Ballot in May 2022

PACP GitHub: https://github.com/HL7/CDA-pacp

PACIO

- Have been looking at what the Gravity project has done

**STU2 Consideration – Leverage pattern for PACIO**

*Goal:* Develop consensus-driven data standards to support use and exchange of data in the Post Acute Care system.

Domains grounded by the ICF "International Classification of Functioning, Disability and Health (ICF)"

- Based on thegravityproject.net

ADI
**Reassessment Time Point**

**Current Status**

- **STU1 (Patient-authored Information)**
  - Block Vote 2 approved by HL7 Patient Empowerment (7 tickets)
  - Working on dispositions for Block Vote 3
  - Working on definition of Must Support

- **STU2 (Practitioner-authored Information)**
  - Continued working with the adjudication spreadsheet, used to perform an environmental scan of existing forms across states
  - Ensure we reflect the ePOLST/CDA concepts in our environmental scan
  - Engage HL7 Orders and Observations to gauge their stance on Portable Medical Order data exchange using FHIR
  - Targeting the September 2022 ballot

- **HIMSS**
  - Following up with interested parties from HIMSS session

- **July 2022 CMS Connectathon**
  - Test STU2 version of IG (practitioner-authored information)
Current Status

- **Currently working on Block Vote 2 ticket resolutions**
  - Decided to not address clinical timepoints and focus instead on administrative timepoints for STU1 publication
  - Further refinements on relationships between re-assessment timepoints and clinical impressions to address ballot comments
  - Define more clearly how re-assessment timepoints link to assessment data
  - Defined search parameters and combinations

- **May Connection**
  - Testing as part of an integrated use case

Draft Domain Value Set Approach for Functioning

**SPLASH PACIO HIMSS Interoperability Showcase**
Harmonization

**Harmonization and Re-use Thoughts**

- Harmonization of resource use
  - CarePlan and Condition in Advance Directive Interoperability (ADI)
- CarePlan profile re-use and harmonization
  - eLTSS and MCC
- Harmonization of codes
  - Multiple codes for the same concept in a different context in Post-Acute Care Assessments
  - Availability of International Classification of Functioning, Disability and Health (ICF) codes

**Thursday Q2**

Joint meeting - PC hosting SDWG

**Topics:**

- Cont. provenance mapping topic (if needed)
- How to represent change patterns of a condition - Tracking Improving, stable, deteriorating patient conditions
  - FHIR-36197 - Representing improving | deteriorating patient responses in R4/R5 Condition resource
  - 2022-05-12 Changing condition trends-info exchange requirements and options.pptx
- Discussion:
  - Stephen presents deck with overview of the different options and overview of elements that match, challenges
  - Time dimension
  - Evidence dimension
  - Intervention (assessment of what? patient, disorder, intervention?)
  - MikeP: does stable mean unchanged or not dying. We have more than 3 values.
  - Condition specific, context specific? What are reason for not choosing Observation: because objective?
  - Suggestion for post co-ordination using condition
  - May have implementation difficulty with the captured data
  - Question about referencing the prior capture of this information. ClinicalImpression has previous that allows this.
  - Tom: it's part of the condition, logically. Jay: or of snapshot.
  - How do EHRs do this. As part of condition?, in flowsheet?
  - Why are we going over this on the SD call? To avoid surprises.
  - SD is pretty busy; will let PC design in FHIR first & then look at translating.

**Provenance:** as per yesterday. FHIR/CDA Translation team to bring SD very concrete, specific questions, not design artifacts to approve.
Thursday Q3

**Learning Health System**

*Topics:*

Virtuous Cycle Project - registries + quality improvement

Thursday Q4

Joint meeting with Learning Health System

*Topics:*

Patient-Centered Care Team