**HL7 Patient Care WG**

**FHIR Resources Management**

**Meeting Minutes**

**September 4, 2014**

Participation Information

Phone Number: +1 770-657-9270

Participant Passcode: 943377

Web Meeting Info

www.webex.com

Meeting number 198 139 396

**Attendees:**

Elaine Ayres

Stephen Chu

Emma Jones

Donna Quirk

David Hay

Laura Heermann Langford

Susan Campbell

Matthew Graham

Rob Hausam

**Agenda:**

1. Review Agenda
2. Review of scripts for three scenarios – reformatting to narrative.
3. Review of value sets needed to support resources (identified 5 – 6 empty slots)(need strawman value sets)
4. FHIR DSTU comment on AdverseReaction resource – Stephen commented
5. Orderable/care plan resource status values – issue of dates for entire plan vs. goals and/or participants? (Emma’s response)
6. Proposal decision – review, f/u and action plan
7. Review and voting on change request proposals for DSTU FHIR resources
   1. Review list and discuss
8. Referral request – any outstanding issues?
9. Clinical assessment resource – awaiting session in Chicago – Wednesday Q3 PC hosting
10. Draft resources
    1. Risk assessment – review (PC is an consultant group)
    2. Contraindications - review (PC is an consultant group)
11. C-CDA on FHIR
12. Next meeting September 11 at 5 PM EDT -- cancel. Send out action item list.

HL7 registry for profiles – will set up a registry for value sets – David has noted the development of this. Each profile will have a URI. A profile will point to a value set with a unique URI.

Approval of previous meeting minutes

Move/second: Abstain: ; against: ; in favour:

**Scripts:**

Suggestion: narrative with patient inputs of sign/symptom complex and patient self diagnosis and clinician evaluation.

***Decision***: format to be narrative with description of contexts to help clinical interpretation of the data

Post on the website with making sure most recent versions are available.

User Interface – select a profile – open it and enter the data. Not slated to be an EMR.

Next week call – show user interface or Tuesday Q5.

**Value sets needed to support resources**

Spreadsheets from David/Lloyd and Julie Chan: about 6-7 elements still require value set

PCWG to work on providing example valuesets for use in connectathon

Longer term: should work towards providing formal valuesets

Medication – a couple of missing items: PCWG to review and work on suggestions; and contact Pharmacy WG for opinion/inputs

Stephen and Elaine will send David comments.

**Orderable/care plan resource status values – Laura is extending questions.**

**Emma Jones – Home Care Example**

**1. Do you have a status value for your care plan? E.g. planned | active|completed|on hold**

**[Response] care plans are either active or inactive or we also list ‘Not used’ – all those remaining that are available for the clinicians to select. May have more than one care plan at a time.**

**2. Do you have a status of “proposed”?**

**[Response] We have a status of ‘Under Consideration’. (During the assessment process) These are care Plans that can be ‘attached’ as the user is going through the patient assessment. They become ‘under consideration’ so that the clinician can then review when the assessment is complete to see which care plans they should select that requires skilled intervention for this episode of care. Once assessment is complete determine the correct level of care.**

**3. Do you have a date for each version of the care plan or do you use a status of updated or do you use a combination of updated as of with a date?**

**[Response] The care plan has an active date, it can only become active if at least one goal or one intervention is determined. *If updated – presume new active date.***

**4. Do you have a separate date for each change of a goal?**

**[Response] Yes - At least one goal or intervention has to be the same as the initial date of the Care Plan, after that, goals can be added or discontinued. We have modifiers that might change, but to retain hx, the goal/intervention should be ended and a new instance started. Are goals “On hold” – yes.-**

**5. Do you have a separate date for each change of an activity?**

**[Response] Yes - If changed via discontinue and start new**

**6. Do you have a status of approved or modified by a participant (Provider).**

**[Response] We think of Care Plans that are associated to the skilled clinician. All of the care plans for the patient go on a ‘Plan of Care’, which has other components besides goals and interventions. Typically in Home Health the certification of that Plan of Care is signed by the attending physician, and is recertified with an updated POC every 60 days. If providers you mean insurance companies, they can ask for that POC at any time. *Approver usually the provider of record – modification by other providers might be local policy.***

**7. Does the participant status have a date associated with it?**

**[Response] Yes - If the participant is the physician signing the POC, it does have a date signed. If you are referencing the individual care plans, we use a true electronic signature framework so we capture a sign\_id in the ui and db**

**Proposal Resource – Note that we decided to create a new Procedure Order**

Need someone from PCWG to create resource proposal – need to verify need to instruct someone to do a procedure order proposal. Procedure Order should be an OO resource? Ask OO.

For education how would you specify – a procedure is an action that is performed on a patient. Should be able to accommodate education.

David Hay’s Blog re Connectathon Recap:  <http://fhirblog.com/2014/07/26/clinical-scenarios-in-fhir-2/>

David Hay’s Blog on clinical examples: <http://fhirblog.com/2014/08/08/creating-examples-in-fhir/>

Scripts:

1. Acute Condition - Laura
2. Chronic Condition – Stephen (Kevin has some additional use case information)
3. Allergy and Intolerance – Russ and Elaine

**C-CDA on FHIR** – looking for profile instances that reflect specific entry templates in C-CDA.

Table below from the FHIR wiki under Ballot Prep link: shows C-CDA entry level templates mapped to FHIR resource.

FMG has noted that WG have a lot on their plates.

|  |  |  |
| --- | --- | --- |
| Patient Care | Allergy Problem/Concern Act | AllergyIntolerance, List |
| Patient Care | Family History Organizer | FamilyHistory |
| Patient Care | Instruction(s) | Procedure? |
| Patient Care | Plan of Care Activity Act/Planned Act | CarePlan |
| Patient Care | Plan of Care Activity Encounter/Planned Encounter | CarePlan |
| Patient Care | Plan of Care Activity Observation/Planned Observation | CarePlan |
| Patient Care | Plan of Care Activity Procedure/Planned Procedure | CarePlan |
| Patient Care | Plan of Care Activity Substance Administration/Planned Medication Activity | CarePlan |
| Patient Care | Plan of Care Activity Supply/Planned Supply | CarePlan |
| Patient Care | Problem Concern Act (Condition) | Concern |
| Patient Care | Procedure Activity Act | Procedure |
| Patient Care | Procedure Activity Observation | Procedure |
| Patient Care | Procedure Activity Procedure | Procedure |
| Patient Care | Reaction Observation | AdverseReaction |

**Referral Resources**: update from Stephen Chu

**Clinical Assessment**: <http://fhirblog.com/2014/07/30/fhir-clinical-scenarios-nutrition-assessment/>

Chicago meeting: Wednesday Q3 – joint with OO and FMG