HL7 Care Plan Meeting Minutes

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Agenda:

Review discussion from last week’s call

Review DAM Progress

Create Next Steps

**Review Discussion from last weeks’ call**

Recap of call with S&I Framework Team that occurred last week to this group. Including review of Stephen’s notes from the meeting.

Hi All,

Thank you for participating in the joint conference call between ONC/LCC and PCWG Care Plan group. The discussions are extremely interesting, productive and useful for all participants.

I summarise my thoughts arising from the discussions in the following:

(1)    There are terminology and definition alignment issues (within the health and health informatics community) that need to be addressed urgently and effectively

(2)    Care plan can be essentially be divided into three key constructs: (a) clinical, demographic and financial/administrative contents that drives the care plan design and implementation; (b) structure that represents the structural components of a care plan; (c) dynamic behaviours that drive the care delivery and care plan exchange activities

(3)    The uses cases developed by PCWG covers both the contents and behavioural constructs. The use cases developed by LCC appear to cover the behavioural aspects especially in relation to care plans exchange

(4)    There are two broad categories of risks: (a) intrinsic risks that are related to a person’s risk factors, barriers and their implications on health risks and health concerns; (b) extrinsic risks that arise from the treatments or interventions that are planned and implemented. Extrinsic risks are manifested as inbound and outbound risks in care plans

(5)    Intrinsic risks (risk factors, barriers, health risks) and goals may be organised into hierarchies

(6)    Intrinsic risks, goals, interventions and outcomes are related to each other in \*..\* relationships

(7)    There is definitive needs to rate/rank risks, prioritise goals and interventions

(8)    Barriers can block interventions but not goals [I personally believe that barriers while may not necessarily block goals, do often result in modification of goals]

(9)    There are significant alignment between the thinking and design of ONC/LCC work and HL7 Care plan work

(10)There are also differences between work of the two groups. The plan is for the differences to be clearly documented and for both groups to harmonize those areas of differences before the September Care Plan DAM ballot

(10.1) Model updates and changes as discussed in earlier calls (refer to slide deck from Russ Leftwich).

 (11)ONC/LCC and HL7 Care plan group will organise conference calls to progress the harmonization activities

(12)HL7 Care Plan project team will work with Structure Doc on Care Plan CDA-IG development with the aim of aligning the work of two groups.

(13) FHIR Issues. / Alignment – see notes below

I have uploaded the LCC slide decks to the Patient Care wiki site:

<http://wiki.hl7.org/index.php?title=Care_Plan_Project_2012>

The ppt file is split into two pdf files because of the file size.

Russ will be the conduit between the two groups to progress this extremely important agenda.

Look forward to your continuous participation and contribution.

Regards,

Stephen Chu

Participants of previous call confirmed this is a good representative list of the conversation.

Suggestion made to include several examples (instances) of the care plan in the DAM, as a way of evaluating the model. (even a UML instance diagram, spreadsheet, key scenarios producing UML instance diagrams).

 These need to be created from the storyboards and the content identified in the IMPACT data set or the model.

 Storyboards may need to call out the barriers in more detail…..

Items that may need to be added to the list…..

 FHIR – does there need to be anything addressed there?

 Care Coordination Group – Care coordination group will use this model.

Would like to be sure the S&I team also looks at the list and determines it is the list they agree to work towards.

Need to wrap a project plan around this list. Dates, sequence, owners, etc.

FHIR

* Gordy Raup has been following the work and not much at all has happened yet.
* FHIR is not going to make a big implementation of the Care Plan DAM in the near future.
* What they are going to do is create a slimmed down version of the model.
	+ It has been said that if you strip down everything and just think of it as a “goal”. Then that is all it is.
	+ FHIR has two groups – FHIR management group and FHIR board (which reports to the executive board).
	+ FHIR model is small enough – perhaps we create a wiki page that maps the two models, and explain/align through the wiki page.
* Problem is two differet design philosophies between CP DAM, CCS and FHIR. CP DAM is looking at the complete system, CCS is looking comprehensive, FHIR is looking at the bare minimum and trying to implement quickly. What are the absolute minimum of the model and map (cross reference) to FHIR.

 Our issues

* + - They are confusing the definitions and terminology
		- Some of what they have is out right wrong
		- They are not even willing to listen and discuss…..

Comment – we are not going to be able to change their opinion. But suggest, as we get closer to the end, we make an attempt to articulate the work we have achieved and the model we are moving forward does or does not relate to their work.

Also suggested to engage in the comment period of the FHIR model and submit comments thoroughly.

FHIR philosophy – only use what exists today, to make it happen quickly.

**Review DAM Progress**

* More issues than realized with the storyboards that need to be addressed.
* Need to go through text in each section of the DAM document in anticipation of the ballot submission.

**Next Steps:**

To Do:

Address the 13 items above….

Refine the storyboards

Review the Model and the data elements against, S&I, IMPACT, CDA, IG, need to address the various nuances. What is the goal? The list of items and the cardinalities. Need to address the issues the Emma identifies for maintenances.

 Conceptually they are different things, structurally they are the same.

Address in DAM – the issues of reconciliation that will be needed. Currently it is recognized as an issue and that CDSS should be applied to help with the reconciliation (conflicts, etc). Need to describe the care plan as it should be first structurally – then can address the tools and function needed to make it work and be usable in the clinical environments. Reconciliation is initially addressed in the CCS. Not all will be resolved by the computer – but could be computer aided.

Going forward –

Our fortnightly calls – time box, the 13 items and the DAM document so that progress is made on both.

Laura to draft the project plan for the these items with any other thoughts on action steps or questions to be answered and send out to the team.