**Clinical Engagement with FHIR Resources (Clinical Connectathon)**

Friday May 15, 2015

Expected Attendees = 18

**Approach**

* + Break into 2-3 small groups. 4-6 participants each group
	+ Each team has - FHIR core team member, facilitator, and then the team members...
	+ Pick 2-3 resources (one per group)
		- Clinical Impression
		- Care Plan
		- Procedure

As a large group before moving into small groups…

 Run through an example (led by Viet)

* You have a patient on 3 med and want to prescribe 2 more.
* Show how the FHIR medication prescription resource is reliant on medication resource but it is separate from the ….? (I missed what Viet Said here)
* Demonstrate the process and expectation of each small groups work through the example.

The schedule:

* 8:30-9:30  (1 hour,) Run through the specific example of 3 meds in place and want to add 2 more and resource (medication prescription) and walk through what is expected of each group with their assigned resource.
* 9:30-11:00 (1.5 hours) breakout into groups of 4-6 have them focus on clinical impression, Care Plan, and Procedure
	+ Provide in advance very specific things we want to include in the care plan, it is too much to provide a whole clinical scenario),
	+ Instruct to to not argue about all the components of the care plan - just add the items listed/Requested (i.e. med, activity, diet, preference, goal),
	+ how would each of these be used in the resource of study?
	+ What interconnections are needed? reference resource vs codable concept?
	+ Ask - Does FHIR support….
		- How long has a patient been… (on a medication)
		- How long has a patient been… (on this dose?)
		- How would FHIR represent that?
		- How do I document a patient doesn’t tolerate or “like” a medication?
		- I create/gather this information in System A but I want to use it in System B… How does FHIR support this?
* 3= 11:00-12:30 (1.5 hours) Bring it together….
	+ Come back together as a large group
	+ Discuss how would we put all of the group work it into a common GUI? Workflow? ….
* 4 = 1:00-2:00  (1 hour) – Recap/ Discuss Plan for next time
	+ What went well, what didn’t go well.

**Clinical Data to use:**

Patient = 64 year old Female with hypertension and CAD.

**Meds (to use for the example during the 1st hour)**

     3 she is on:

          Metropolol 25 mg tab 1x/day

          ASA 81 mg/day

          HCTZ 25 mg/day

     2 more to add

          Increase the metropolol - to 50 mg

          Add Lisinopril 20 mg/day dispense 30 with 3 refills.

          Add Glyburide 5 mg/day

**Group 1 = Clinical Impression**

     Observation -

          (S) Patient has increased thirst and urination

          (O) Lab - HgA1c of 7.4

          (A) Clinical Impression ? What is the provider doing

     Diagnosis is - patient has diabetes.

**Group 2 = Care Plan**

     Diet - Sugar free (new) and low fat (for last 2 years)

     Activity - walk 1/2 mile/day (outside or on treadmill)

     Preference - Husband to be present at appointments

     Goal - diabetes in control.. HgA1c < 6.0, no insulin needed.

**Group 3 = Procedure**

     lab draw

     referral for eye exam at the ophthalmologist.

     Diabetic education

     Follow up visit.