IPS Face 2 Face meeting

Partially Discussed

@Phast

2017-03-21

15.45 - 17.15

Notes in red

Agenda

- Provenance
- Identification of the “type of Patient Summary”:
  - Single vs Multi Encounter;
  - Single vs Multi organization;
  - clinical act VS automatic collection VS mixed mode (see also provenance)
  - Header
- Revision of the Agenda

Approach

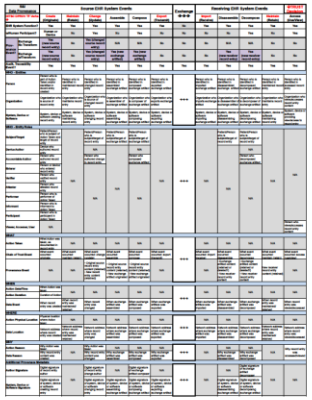
- Should we introduce the problem and then split in two / three sub-groups ?

PROVENANCE

See http://wiki.siframework.org/Data+Provenance+Pilots+Executive+Summary for a description of the problem

Provenance

- This initiative has creted :
- **HL7 CDA® Release 2 Implementation Guide: Data Provenance, Release 1 - US Realm Draft Standard for Trial Use December 2015**
- **And this matrix**



Provenance

- **Assembler Generated Document With Provenance**
  - *The Assembler Generated Document with Provenance template constrains the CDA to create a document comprised entirely of preexisting content. Such preexisting content is generated by other Authors, which may also have used assembly or composer software.*

Provenance

- **Device Generated Document With Provenance**
  - *The Device Generated Document with Provenance template constrains the CDA to create a document authored by a device, which is comprised of device generated information, and may include provider selected preexisting sections and entries authored by other persons or devices with provenance information intact.*

Provenance

- **Patient Generated Document With Provenance**
  - *The Patient Generated Document with Provenance template constrains the CDA to create a document authored by a patient or their personal representative (hereafter included in the concept of patient), which is comprised of patient generated information, and may include patient selected preexisting sections and entries authored by other persons or devices with provenance information intact*

Provenance

- **Provider Generated Document With Provenance**
  - *The Provider Generated Document with Provenance template constrains the CDA to create a document authored by a provider, which is comprised of provider generated information, and may include provider selected preexisting sections and entries authored by other persons or devices with provenance information intact.*

Provenance

- How we would like to deal with it ?
- Adopt the DPROV IG ? (really constrained…)
- Mention the problem in the introduction, without providing any specific constrain at the level of templates ?
- Include explicitly the elements that should be used for tracking these data (as optional)
- Other ?

TYPE OF PATIENT SUMMARY

Type of Patient Summary

- Related to the previous topic
- Do we want to keep track of information that describe the “context” of creation of the PS ?
  - Single vs Multi Encounter;
  - Single vs Multi organization;
  - Clinical act VS automatic collection VS mixed mode (see also provenance)

Type of Patient Summary

- In epSOS/eHDSI (only the third item is actually handled with a simplified approach)
  - automatic collection => author device
  - Provider => author human
  - Mixed => both
- Do we want to do more ?
- In case how ?

HEADER

Header

- clinicalDocument.effectiveTime : different level of precision
- Different type of adddress
  - US city and street line required
  - EU at least one element in the AD is required
  - US no mixed content, (neither for EU even if not specified
  -)

Header

- US raceCode (SHALL); sdtc:raceCode (MAY); ethnicGroupCode (SHALL); sdtc:ethnicGroupCode (MAY); not used or prohibited in EU
- There are specific information required or suggested for the EU PS…
- How we would like to proceed ?