

Meeting Minutes

HL7 CDA Personal Advance Care Plan Document Implementation Guide Project

Prepared by: Lisa Nelson

Industry Team

October 20, 2015

RECORDING:

<https://www.youtube.com/watch?v=1W9uwjJFVUA>

(Please report issues with accessing the recording to LisaRNelson@cox.net)

ATTENDANCE:

Present	Not Present	
Bob Fine	Dan Hanfling	Dan Morhaim
Douglas Renfield-Miller	M'Lynda Owens	Fred Mirarchi
Evelyn Gallego	Remington Johnson	Jacob Reider
Judy Peres	Brian Scheller	Joseph Schneider
Scott Brown	Tony Chou	Jude Gallagher
Stephen Chu	Swapna Bhatia	Leslie Kelly-Hall
Jeff Zucker	Taima Gomez	Mike Wasserman
David Tao	Terry O'Malley	John Derr
Monica Murphy		Paul Coyne
Lisa Nelson		

AGENDA:

Review Goals & Schedule

Review of Feedback

Source Example Content Review

Vocabulary – Focus on Standard Questions

Other Content

Overview of Personal Advance Care Plan Document

Content Example

Review of Relationship to existing Advance Directives Section and Care Plan Document

Open discussion

DISCUSSION NOTES:

Lisa apologized for technical problems launching the distributed GoTo meeting link. She encouraged anyone who missed the meeting to review the recording using the link included in the minutes.

I. Goals and Schedule

We reviewed that the scope and goal of the project has not changed over the past month and following review at the HL7 face-to-face (F2F) working group meeting. We continue to establish a standard CDA format to enable “interoperable” digital sharing of a person’s Advance Care Plan information. The advance care plan information includes health agent information and information regarding a person’s care goals, preferences, and priorities at end of life, upon death, and for care planning in general.

Stephen Chu noted that it would be useful to clarify that preferences for care can be both “negative and positive”, meaning that the preference can encompass care that one wishes to receive as well as care that one wishes not to receive. He asked that we include clarification explaining that the intention is to express both positive and negative preferences.

All needed project approvals were completed within HL7. The Technical Steering committee provided the final level of approval on 10/14 and the Notice of Intent to Ballot in the January cycle will be submitted on 10/22.

II. Review of Feedback

Lisa thanked everyone for the references they supplied to sample advance directives and other related articles. She reviewed the analysis performed to summarize, compare, and categorize the types of content recommended from eight sources representing a variety of different types of organizations. Source content was identified using a question that corresponded to the content (“the Jeopardy Approach”). The question was then compared to a set of previously established “standard questions” established as a basis for the analysis. If the question matched a question in the base set, it was entered on the same row. If it had no corresponding question in the base set, it was entered on a new row, and a new question was added to the base set. Next, all questions determined to be similar were further analyzed to determine if they were equivalent to the base question, or if their intent was broader or narrower than the base question. Finally, all questions in the base set were categorized to determine a set of “information types” which classified the information into groupings that generally summarized the different types of information discovered in the analysis.

The types of information could broadly be grouped into the following categories:

1. Information related to establishing Health Care Agents
2. Goals, preferences, and priorities for end-of-life care
3. Goals, preferences, and priorities following death
4. Goals, preferences, and priorities not specific to end-of-life care or after death
5. Issues related to signing, witnessing, and notarizing the information

The spreadsheet will be distributed with the meeting minutes.

Sample Use Cases will also be documented in Volume 1 of the HL7 Implementation Guide.

The Use Cases will describe clinical scenarios which demonstrate the following situation:

1. Create and share an Advance Care Plan
2. Update and share an Advance Care Plan
 - a. By replacing it with a newer version

- b. By establishing an end date for when it expires
 - c. By explicitly revoking it
3. Request and access the current version of a person's Advance Care Planning Directives in a situation that is an Emergency or Critical and they can't speak or make treatment decisions
4. Request and access the current version of a person's Advance Care Planning Directives in a situation that is not Emergency or Critical situation and the person is able to speak for his or herself.

Monica Murphy-Brown said that she had experience documenting use cases and would be willing to work with Lisa to write up some relevant scenarios to demonstrate the need for and use of Personal Advance Care Plan information.

III. Overview of Personal Advance Care Plan Document

Lisa reviewed conceptual diagrams created to show how the proposed Personal Advance Care Plan (Personal ACP) information related to information exchange standards previously established Consolidated CDA (C-CDA) Advance Directives section of a clinical summary document and the Care Plan document.

Lisa explained that the optional Advance Directives section and entry templates would enable a clinical summary document to reference a Personal Advance Care Plan Document supplied by an individual. The Advance Directives section also records the established health care agent for the patient during the summarized encounter. This information could be informed by the Health Care Agent section of the Personal ACP. The type of information included in the person's Advance Care Plan could be summarized to make it faster for clinicians to know what type of goals, preferences, and priorities the person has documented.

Lisa also explained that although the C-CDA Care Plan document template does not require or state the Advance Directives section to be optional, it is an open template, so inclusion of and Advance Directives section is not prohibited. Existing Care Plan document samples collected for another project do show inclusion of Advance Directive information. If a Care Plan document were to include an Advance Directives section, this would enable a care plan document to reference the Personal Advance Care Plan Document supplied by an individual. The Advance Directives section also would record the established health care agent in effect for care planning purposes. This information could be informed by the Health Care Agent section of the Personal ACP. The type of information included in the person's Advance Care Plan could be summarized to make it faster for clinicians to know what type of goals, preferences, and priorities the person has documented.

Additionally, decisions made during a clinical encounter or made while establishing a person's care plan, could more easily be informed by the patient's goals, preferences, and priorities.

Diagrams will be distributed with the minutes.

IV. Discussion of Project Name

Lisa reported that no clear consensus had been reached during the HL7 F2F regarding the project name. Some commenters had provided rationale for including the term “directives” in the title because it would help relate the project to “advance directives”, something they already understand. Meaningful Use Stage 3 final rule also includes the term “advance directives” as an example of patient health information capture. Scott Brown provided a summary of 3 key issues to be addressed by the project name. The summary is included on the project wiki site. [http://wiki.hl7.org/index.php?title=Personal Advance Care Plan Document](http://wiki.hl7.org/index.php?title=Personal_Advance_Care_Plan_Document)

Dr. Fine said he felt the name Personal Advance Care Plan was appropriate and offered other possible variations, such as: Personal Advance Care Information and Personal Advance Care Preferences. Stephen Chu again expressed concern over potential confusion with other work that is focused on “Care Plans”. The option of replacing the term “Care Plan” with “Care Planning Information” was considered. In general everyone was against adding more words that would make the title longer. Stephen preferred Personal Advance Care Information over Personal Advance Care Plan. Evelyn Gallego reported that CMS was working on a project in a similar space and they had used the term “Personal Action Plan”.

Lisa reminded everyone that the title used to go to ballot would not be a “done deal” and that likely the title would undergo further consideration and revision as part of the ballot comment reconciliation process.

V. Open Discussion

No time for additional discussion. Lisa again thanked all industry participants for their participation and input on the project.

SUMMARY OF ACTION ITEMS:

Responsible	Action
Lisa Nelson	Distribute minutes, presentation slides, link to recording, list of sample advance directive documents, and instructions for non-members to participate in the HL7 ballot.
Monica Murphy, Scott Brown	Assist with creation of Use Case Descriptions

Addendum:

Date	Name	Description
10/22	Lisa Nelson	After serious consideration, Lisa has decided not to change the working title of the project prior to going to ballot. Given that this issue will come up again during ballot reconciliation, she opted to minimize the number of project title changes by holding off on making revisions to the title until ballot reconciliation. The NIB was submitted using the current working title of “Personal Advance Care Plan Document”.
10/22	Lisa Nelson	Fred Mirarchi had previously asked to clarify why POLST and MOLST documents were considered out of scope for this project. We didn’t

		<p>get a chance to review this topic during the meeting, so this additional information was added following the meeting.</p> <p>A Physician Oder for Life Sustaining Treatment (POLST) or Medical Order for Life Sustaining Treatment (MOLST) is a different type of document which is not authored by a person. This type of document is authored by a clinician. A POLST or MOLST document could referenced by a Personal Advance Care Plan Document so as to help make sure that clinicians have a copy or a link to reference this clinical order. The exchange format for expressing a POLST or MOLST would need to take other standards for expressing medical orders into consideration and would not use a template designed for a patient generated document. Efforts to define an exchange standard for representing a POLST or MOLST using CDA could be informed by this work, but it would require a different specification to be created.</p>
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ADJOURNMENT:

The meeting ended at 6:02pm ET.

Next meeting will be scheduled for Tuesday, November 17th at 5:00pm ET.

1. Please join my meeting.

<https://global.gotomeeting.com/join/369226397>

2. Use your microphone and speakers (VoIP) - a headset is recommended. Or, call in using your telephone.

Dial +1 (646) 749-3122

Access Code: 369-226-397

Audio PIN: Shown after joining the meeting

Meeting ID: 369-226-397

ATTACHMENTS:

1. Meeting slide deck.
2. Summary of Source Advance Directive Content Analysis
3. Conceptual diagrams for relationship of Personal Advance Care Plan document information to information in an Advance Directives section in a Clinical Summary and to information in a Care Plan document