**HL7 Patient Care Work Group**

**Allergy/Intolerance/Adverse Reaction Topic Sub-Group Meeting Minutes**

**Date: January 27, 2016**

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Co-Chairs: Stephen Chu/Elaine Ayres Scribe: Elaine Ayres

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| --- | --- |
| **Name** | **Present on January 27, 2015** |
| Elaine Ayres | X |
| Stephen Chu |  |
| Rob Hausam | X |
| Bit Vo | X |
| Russ Leftwich |  |
| Emma Jones | X |
| Lisa Nelson | X |
| Michelle Miller |  |
| Shelly Spiro | X |
| Brett Marquard |  |
| Russell McDonnell | X |
| Julia Skapik |  |
| Dianna Dodd | X |
| Jay Lyle | X |
| Larry McKnight |  |
| Hank Mayers | X |
| Lindsey Hoggle | X |
| Ben Skupien |  |
| M’Lynda Owens | X |

**Agenda for January 27, 2016**

1. Minutes of last meetings – January 6th, 2016 - <http://wiki.hl7.org/index.php?title=Allergy/Intolerance_Project_Conference_Calls_and_Meeting_Minutes>
2. Continue substances discussion - <http://wiki.hl7.org/index.php?title=January_2016_WGM_Orlando,_Jan_10_to_Jan_15#Patient_Care_Wednesday_Q4>
   * 1. JET Project re medications and food – recap of presentation at Orlando WG meeting
     2. Discussion of other data sets
     3. Next steps for development of intensional data sets
3. Question re NDFRT codes - Chemical/Ingredient or MoA code type vs. NDF-RT EPC (Established Pharmacologic Class) as in SPL
4. C-CDA 2.1 comments update
   1. Update on severity
   2. Discussion on Problem Status value sets
5. SPL for Food update -
6. Agenda for meeting on February 10
7. **Minutes:** Move: Abstain –, Negatives –, Approve –
8. **JET (Joint Exploratory Team) Project Regarding Substances –Update from Orlando**
   1. Overview – Joint Executive Task Force VA/DOD -- human review of allergy lists. Used the same approach for reactions. This is only for drug allergies at this time. Using RxNorm – have top 100 list as well as others. Actual technique used – RxMatch an NLM tool with ingredient codes. Will use NDFRT classes for drug classes. The follow-on has not yet been determined. Want to first lock down on top 100 and top 95%. Will mapping to synonyms be done? Will use the list at VA/DOD as described by RxNorm. Using a patient described substance, how will that mapping be accomplished, especially for data coming from other systems. In original data sets – many synonyms for the same drug. Use of the common unique identifier from RxNorm.
   2. Also have a list for environmental allergens and other non-medicinal allergens. Used UMLS CUI’s – linked to SNOMED and UNII’s. Not sure if VA has moved forward with SNOMED.
   3. How will the list be used, and what happens if a substance is not on the list and you wish to add such as a substance? Data sets were robust, so the bottom 5% may be the only missing items. 492 drugs represent the top 95% - will be able to find in the data set. List was set as a baseline – but more terms can be added. Goal is to use the same identifier as others are using. This will help aid the clinical decision support systems.
   4. Cerner work – last 5% value is limited. Like passing text vs. codified value.
   5. Applicability to the FHIM – and combining with data from other sources? The VA/DOD hopefully will allow others to use.
   6. MED RT – a separate effort to replace NDFRT, but may well complement based on SNOMED CT concepts.
9. Next steps: Three tracks – 1. Journal article with VA/DOD, 2. Analysis of Cerner data set against VA/DOD, 3. Plans for HL7 – create an international data set. (Terminology mapping to SNOMED CT?). Should use substance ingredient as is aligned with RxNorm. If the analysis is done with the Cerner data set – do we need a US version and an international version? International will need realm specific names. Current US regulations require RxNorm. OpenMedicine coming out of Europe – starting with prescribing. Have discussed issues with using SNOMED and RxNorm. HL7 is involved – so need to harmonize. KP data is still pending analysis. The FHIM data along with gov data is all US centric. What is the depth and breadth of SNOMED vs. RxNorm? Publication of ingredients and substances should mitigate the need for more frequent updates. Mappings exist at the ingredient level. Internalization of FDA approaches.

DOD – no non med allergies. VA provided food and environmental substances – mapped to UNII and SNOMED. As provided by the source. Terms are sitting in the VA extension.

**3. Question re NDFRT codes - Chemical/Ingredient or MoA code type vs. NDF-RT EPC (Established Pharmacologic Class) as in SPL** and plan of treatment vs. goals.

Many unique identifiers but overlap. NCPDP and mapping of MoA, ingredient or EPC – for allergy codes. Move to NDFRT (as per MU) for classification of drugs. The NCPDP classification (35 classes) - but what are the code types. There are 43,000 codes in the file. Use the top 35 NDFRT codes (chemical ingredient) vs. the EPC code (established pharmacological class). Pharmacy HIT collaboration moved the classification project over to USP. Did look at RX CUI’s and UNII. Each organization is setting up their individual clinical decision support process (proprietary databases).

There is a difference between ingredient vs. the mechanism of action.

**3.** Clinical Status discussion for C-CDA Problem Status

Clinical status:  active | relapse | remission | resolved

In quality measures, use terms like controlled and uncontrolled. Do we need to cover all sorts of problems? Do we need a problem status value set – how extensive? Work on the DSTU comments. PSS for C-CDA companion guide – does not need to incorporate new guidance from DSTU comment processing. No anticipation of emergent new guidance.

This does not control what is on a problem list. C-CDA 2.0 provides guidance on how to represent a problem concern on the active problem.

4. Group discussed the severity value set proposed and approved for C-CDA 2.1. Group agreed that the same DSTU comment should be made for C-CDA 1.1 and 2.0 versions.