HL7 PDDI-CDS WG Meeting 04/04/2018

In Attendance: Richard Boyce, Thomas Reese, Xia Jing, Guilherme Del Fiol, Howard Strasberg, Bryn Rhodes, Sam Habiel

Agenda:

-Hello and recap from the last meeting by Rich

-Rich’s introduction to the Wiki page for the project: HL7 PDDI CDS

-Discussion on:

CDC Opioid CDS resources-Bryn introduction

Understanding

Experience sharing

Brainstorm about next steps

\*Wiki page link: <http://wiki.hl7.org/index.php?title=PDDI_CDS>

Meeting information is valid until the end of the year.

The listserv is linked to a forum

Project info and GitHub link can be found here too

The meetings are not recorded right now. However, the meeting minutes can be found on Wiki.

\*Bryn suggested that HL7 has standard ways for document working group activities; the forum is fine; another option to do community engagement is via “stream”. New members can join. The link: chat.fhir.org

\*Rich shares his exploring experience: PDDI in FHIR, CDC opioid CDS page, PlanDefinition, DetectedIssue, CDS hooks responses.

<http://build.fhir.org/ig/cqframework/opioid-cds/integration-documentation.html>

<http://build.fhir.org/ig/cqframework/opioid-cds/process-documentation.html>

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\*Clarification:

DetectedIssue: reasons to make suggested changes

PlanDefinition: represents the response, such as take the suggested actions

Howard mentioned the two ways to hand the case in their real-world practice: have suggestions; not have suggestions

\*A couple of questions:

* What to show in the recommended actions, especially considering the alter fatigue
* It has to be relevant, how to define/implement relevant recommendations?
* What are the best ways to represent the decision tree?
* How to deal with incomplete information in EHR? Open world assumption?
  + Howard experience: if we see information in HER, we assume that is true information; if we do not see information in HER, we cannot assume the information does not exist. Absent information != something does not happen
  + Bryn: only make decisions based on the artifacts and existing information.

\*Bryn introduces the CDC opioid CDS resources, including implementation guide

The hard part: too many DDI. Not feasible to ask clinicians to review each interaction

Artifact perspective: automatic surfacing???(not sure the word)

Process documentation: currently mostly are narratives, how to document the processes in a structured manner?

\* Sam would like to see the technical side of the work, such as a live demo

\*Howard, maybe we should add data confidence level, which can be factored during implementation in a site-specific manner.

\*Rich, maybe we can design some turn on/off option, then some nodes in the decision tree can be modified during implementation.

\*Guilherme: where to draw the line regarding the scope of the working group? Currently, HL7 focus more on data elements, data formats, and interactions. The behavior decisions (such as how to implement the specifications) will be left to implementation and application stages.

\*Discussion on resources

* Guilherme: how about ppt or word document with diagrams? Walk through the flow in different pieces of the existing standards will be helpful.
* Bryn: GitHub has the project information: <https://github.com/DBCG/cqf-ruler>
* Sam: how to implement? How to start?
* The existing materials are specifications, not software yet.

\*Next steps/action items:

* Warfarin as an example medication, value set, in FHIR format, architecture template folder resources/pages
* Simulation, such as to use sandbox environment to represent/build existing PDDI
* To understand the mechanism first, such as CDC opioid CDS, then to prototype or test implementation later. For example, mapping PlanDefinition and DetectedIssue with existing PDDI items (decision tree), to detect what are missing
* Draw high-level diagrams on DDI mappings from the Warfarin – NSAIDs case to PlanDefinition and DetectedIssue resources
* Put ValueSet in FHIR resource format