IHE Work Item Proposal (Short)

# Proposed Work Item: Patient View Visit Summary document content module

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Version: 1.0

Domain: Patient Care Coordination

# The Problem

<Summarize the integration problem. What doesn’t work, or what needs to work?>

Current content profiles do not capture specific information needed to be communicated to a patient about a specific clinical visit. Summary information shared with the patient today, is typically a summary of the entire clinical history, not a summary of a specific visit. Providing the entire clinical history at the end of each visit can be overwhelming and lead to complications related to information overload. The document specifications also forces empty sections to be included in a document because it is a require section. This could cause confusion for the patient receiving such a document.

<Describe the Value Statement: What is the underlying cost incurred by the problem and what is to be gained by solving it? If possible provide quantifiable costs, or data to demonstrate the scale of the problem.>

Providers often need to provide patients a summary of the recent patient visit, in a structured format, and the existing document templates are currently too restrictive and not well-aligned towards what the patient wants to see in such a visit summary.

# Key Use Case

<Describe a short use case scenario from the user perspective. The use case should demonstrate the integration/workflow problem. Feel free to add a second use case scenario demonstrating how it “should” work. Try to indicate the people/systems, the tasks they are doing, the information they need, and where the information should come from.>

Use Case 1

At the end of a patient visit, Dr X wants to send a Visit Summary to patient Y, consisting of a summary of, for example, the list of problems assessed, medications reviewed and updated, plans and goals. However, Dr. X has to send the patient a list of medications, problems, plans and goals. There is not an easy way to indicate the ones reviewed and updated associated with the visit. Dr. X also has to send the patient a document with sections that were not addressed during the visit because the existing document type specifications require that certain sections be present even when there is absence of data. Filling these sections with No Known, or other placeholder text and entries is not useful, and often confusing, to patients.

Use Case 2 <how it should work>

At the end of a patient visit, Dr X wants to send a Visit Summary to patient Y, consisting of a summary of, for example, the list of problems assessed, medications reviewed and updated, plans and goals. These should be associated with the visit.

# Standards & Systems

<List existing systems that are/could be involved in the problem/solution.>

<If known, list specific components of standards which might be relevant to the solution.>

CDA R2

IHE PCC Medical Document

IHE PCC C-CDA Harmonization

Consolidated CDA

# Discussion

<If possible, indicate why IHE would be a good venue to solve the problem and what you think IHE should do to solve it.>

<A one page proposal is preferred. Please do not exceed two pages.>

Dr X and patient Y both want this Visit Summary to reflect only what happened or is related to the visit. They do not want to have to include information that was not pertinent to the visit. Nor do they want to include information that is required due to document specification rules such as absence of data for a specific required sections.

The development of a Visit Summary profile, where no sections are required (SHALL), and some sections are listed as SHOULD, promotes ease of use for the case where Dr X wants to send a patient-oriented Visit Summary. The Progress Note of C-CDA 1.1 comes close to what is needed.

The proposed Patient View Visit Summary might look like this:

