MITRE / FLUX NOTES **INFORMATION ARCHITECTURE v02**

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This document describes the information that should populate Flux Notes Full within the pre-encounter, encounter, and post-encounter views. It is a mapping of the groups and types of clinical information for the goals of the oncology based provider vs a mapping of the discrete SHR data elements. This document should be used by both design and development as a source for shared understanding for the content populating Flux Notes Full.

It is a map for the future goals and vision of Flux Notes Full based on provider needs. It is also a tool to strategize design and development priorities.

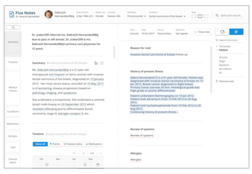
This document requires feedback from the development team for a common v01 agreed upon mapping, and then later providers to refine and expand that mapping.

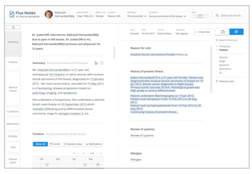
PRE-ENCOUNTER

ENCOUNTER

POST-ENCOUNTER

EXAMPLE SCREENS





GUIDING PRINCIPLES

Emphasis on viewing the longitudinal patient record in "snapshot" form

Emphasis on understanding the overall status of the patient through improved information presentation of the history of present illness

Visualizations focused on the current state of the patient in the context of their longitudinal record

Visualizations support the formulation of next clinical steps

Understanding the reason the patient is coming to see the clinician

Emphasis on capturing new patient information

More emphasis on viewing the latest status of the patient and a focus on changes since the last visit, which may help with patient-clinician discussion

Patient-clinician collaboration in capturing new data during the encounter and generating materials for patient education and understanding

Patient clinician co-collaboration in planning next steps in care

Potential for capturing patient recorded outcomes

Clinical decisions made and captured based partially on patient preferences

Visualizations aid in driving patient understanding of concepts

Opportunity for confirmation and validation of patient medical information

Clinical note creation

Emphasis on the sign off of newly captured data

Healthcare receipt generated

Collection of patient information and reported outcomes after the encounter

CONTENT ON LOAD FOR THE MEDICAL ONCOLOGIST

GLOBAL NAVIGATION

CLINICAL NOTES

PATIENT RECORD MINIMAP

Visit reason

Summary

"Whats new" (new imaging, lab, medications, recent unplanned encounter)

Timeline

Medical history

Medications

Allergies

Labs

Disease status

Clinical trials

Genetics

Pathology

Current sections based on design mockups

GLOBAL NAVIGATION

CLINICAL NOTES

PATIENT RECORD MINIMAP

Visit reason

Summary

"Whats new" (new imaging, lab, medications, recent unplanned encounter)

Procedures

Active conditions

Pathology results

Genetics

Timeline

Current sections based on development. The sections within design vs development differ. These conflicts should be resolved through team discussion and further clinician feedback

GLOBAL NAVIGATION

CLINICAL NOTES

PATIENT RECORD MINIMAP

Visit reason

Summary

Procedures

Active conditions

Pathology results

Genetics

Timeline

ALL FLUX NOTES CONTENT

TOP NAVIGATION

Workflow selection

Condition selection

Basic patient information + portrait

Logged in user name

CLINICAL NOTES

In-progress notes

Previous notes

ALL PATIENT RECORD SECTIONS

SUMMARY

Current diagnosis

Recent lab results

Key dates

TIMELINE

Inpatient event history

Outpatient event history

Disease status history

Medication history

Future information/trajectory (scheduled events, etc)

MEDICAL HISTORY

Conditions

- Active and resolved
- Diagnosis and end dates
- Care team information

Surgeries

- Inpatient and outpatient

Social

- Behavior
- Environment

Family history

- Relation to patient
- Basic relation information (DoB, name, etc)
- Current conditions for each relation
- Health status for each relation

MEDICATIONS

Current medications

- Side effects
- Patient reported outcomes
- Route, dosage/freq, dates, prescribed, refills

Current medication schedule

- Time schedule: day/week/month
- Medication instructions

Timeline for medications

- View of known future schedule
- Current and previous medication history

ALLERGIES

Active allergies

Timeline for allergies

- Skin tests
- severity
- Incidents

LABS

Most recent lab values

- RBC, LDL, others...

Timeline history of lab tests (both panel & individual)

DISEASE STATUS

Current status

Reason & artifacts for current status

Timeline history of disease status

GENETICS

Oncotype, genetic testing

IMAGING

Timeline history of imaging

Imaging in relation to location in body

PATHOLOGY RESULTS

Tumor information

Receptor information

VISIT REASON

Reason for visit

ACTIVE CONDITIONS

Condition name and diagnosis date

Body location of condition

CLINICAL TRIALS

List of clinical trials patient is in

PROCEDURES

Timeline history of procedures (surgical & non-surgical)

ADDITIONALLY CONSIDERED PATIENT RECORD SECTIONS

DIRECTIVE

Advanced directive information

IMAGING

Timeline history of imaging

CAREPLAN/CARE PROTOCOL/PLAN OF CARE

Medication regimen

Care team information