Clinical Notes Implementation

- Workflows
  - CCDA
    - Encounters
    - Procedures
    - Result Organizer
    - Result Observation
    - Reasons for Referrals
    - Hospital Course
    - Notes Section
  - Contrast FHIR expectations
    - DiagnosticReport
    - DocumentReference

Clinical Notes Implementation

- Unstructured Documents, Comments, Flag – how should differentiation occur?
- Association with other “concept” Domains (e.g. Vital Signs, …, etc. and use of LOINC codes)
- Continue to push Discrete data
- Over prescription of clinical notes may inadvertently cause diminishment of discrete data
- Clinical Notes considerations specific to Care Settings
  - Inpatient – May have more discipline specific notes
  - Ambulatory Care – outpatient, home care, community care, etc. – may have discipline specific and concept specific
  - Long term care – May have more ‘free text’ notes than
- Notes Filtering/Searching
  - Are all ‘clinical-notes’ meant to be shared?
  - Will this increase data dumping and increase CDA document size?
  - Tagging concept for easier searching (e.g. Key words) – can this be supported in CDA docs.
Clinical Notes – Potential Action

- Update Companion Guide to include more concise guidance
- Feedback about use of “Clinical Notes” in CDA documents
  - Relationship to use of Discreet data
  - Relationship to CDA document size
- Alignment with FHIR