Clinicalassessment Fhir Resource Proposal
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Performing a clinical assessment is a fundamental part of a clinician's workflow, performed repeatedly throughout the day. In spite of this - or perhaps, because of it - there is wide variance in how clinical assessments are recorded.

Some clinical assessments simply result in a single text note in the patient 'record' (e.g. "Progress satisfactory, continue with treatment"), while others are associated with careful, detailed record keeping of the evidence gathered, the reasoning leading to a differential diagnosis, and the actions taken during or planned as a result of the clinical assessment, and there is a continuum between these. This resource is intended to be used to cover all these use cases.

Note that the Resource is a 'skeleton' that ties together other resources that actually record the clinical information.

The assessment is intimately linked to the process of care. It may occur in the context of a care plan, and it very often results in a new (or revised) care plan. Normally, clinical assessments are part of an ongoing process of care, and the patient will be re-assessed repeatedly. For this reason, the clinical assessment can explicit reference both care plans (preceding and resulting) and reference a previous assessment that this assessment follows on from.

Unlike many other resources, there is little prior art in the modelling world with regard to exchanging records of clinical assessments (there is considerable in the EMR/EHR implementation space. For this reason, this resource should be regarded as particularly prone to ongoing revision. In terms of scope and usage, the Patient Care workgroup wishes to draw the attention of reviewers and implementers to the following issues:

- When is an existing clinical assessment revised, rather than a new one created (that references the existing one)? How does that affect the status? what's the interplay between the status of the diagnosis and the status of the assessment? (e.g. for a 'provisional' assessment, which bit is provisional?)
- This structure doesn't differentiate between a working and a final diagnosis. Given an answer to the previous question, should it?
- Further clarify around the relationship between care plan and assessment is needed. Both answers to the previous questions and ongoing discussions around revisions to the care plan will influence the design of clinical assessment
- Should prognosis be represented, and if so, how much structure should it have?
- Should an assessment reference other assessments that are related? (how related?)
- Investigations - the specification needs a good value set for the code for the group, and will be considering the name "investigations" further

There is another related clinical concept often called an "assessment": assessment Tools such as Apgar (also known as "Assessment Scales"), and this is different to the scope of the "clinical assessment" resource. Assessment tools such as Apgar are represented as Observations, and Questionnaires may be used to help generate these. Clinical Assessments will often refer to these assessment tools as one of the investigations that was performed during the assessment process.

An important background to understanding this resource is the FHIR wiki page (Clinical_Assessment) for clinical assessment. In particular, the storyboards there drove the design of the resource, and will be the basis for all examples created.

**RIM scope**

**Resource appropriateness**

The concept of a ‘clinical note’ is fundamental to recording clinician/patient interactions. Given the wide variety of detail that is recorded, some a simple note to a complex, structured history & examination, some sort of 'backbone' to the recording is required. It will not contain the clinical information - it will link together all disparate resources required to document the interaction.

**Expected implementations**

Any EMR/EHR that is recording the contact (physical or virtual) between a patient and a care deliverer (including clinician)

**Content sources**

existing EMR/EHR systems possibly input from CCDA, openEHR
Example Scenarios

A patient is seen by a Primary care Provider with a sore throat. The symptoms & signs are recorded, and the investigations and treatment plans (including orders) are recorded.

A patient telephones the surgery for advice. The nurse records the patients symptoms and the advice given.

A patient attends a hospital clinical for investigation of hip pain.

A patient is reviewed in hospital during a 'Ward Round'.

Resource Relationships

Will be related to a number of resources - examples include Observation, Condition, Encounter, Patient, Practitioner, CarePlan

Timelines

gForge Users