

BHIP Prototype Specification

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Purpose

OHIT received a BHIP grant from the federal government (SAMHSA-HRSA/CIHS). The purpose of this grant is to demonstrate how HIE technology can benefit behavioral health providers and institutions. In particular, OHIT has decided to build a prototype to show how mock extensions to the C32 CCD could be used effectively for transfers of care using ILHIE Direct. There are 4 documents that are part of this prototype:

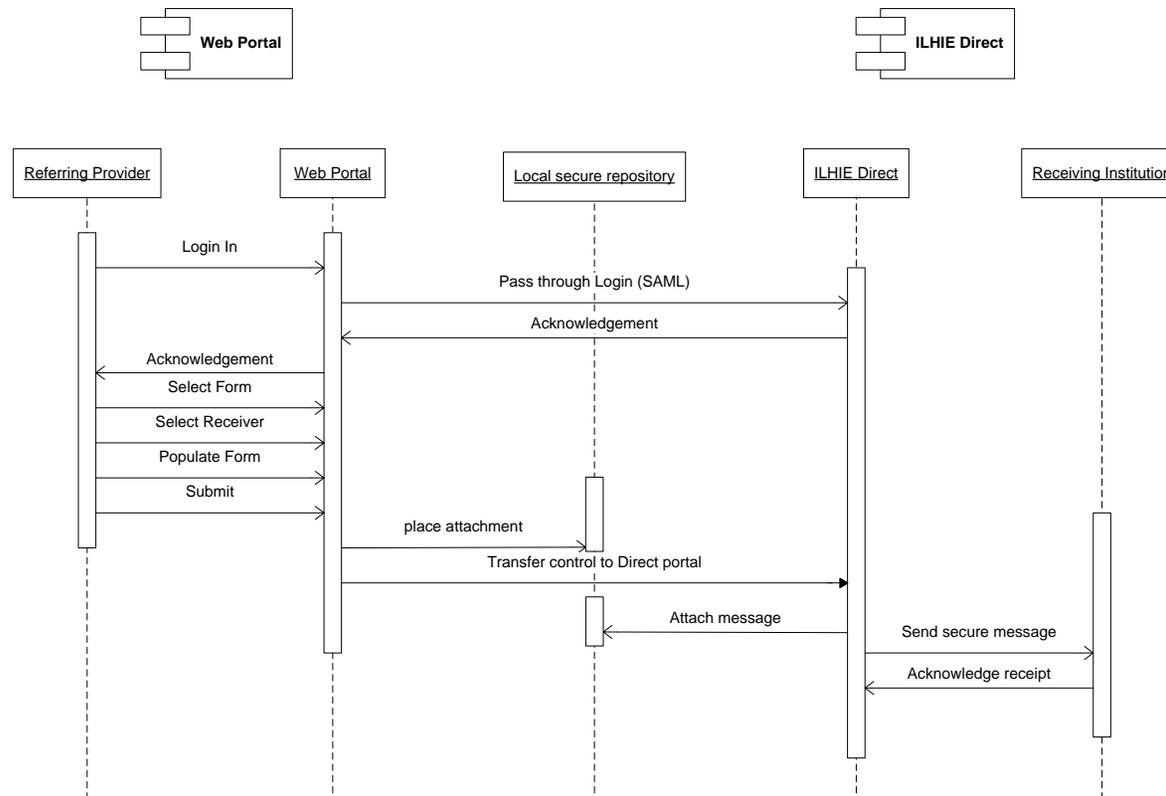
1. Discharge Summary
2. Discharge Instructions
3. Consultation Request
4. Consultation Summary

General Specification

Detailed document definitions are defined below in the **Document Definitions** section. The basic operation of this prototype is quite simple. The (somewhat abused) sequence diagram on the next page shows the intended operation.

1. A provider logs into the BHIP Prototype Web Portal (BPWP).
2. A SAML assertion (or equivalent) is used to pass the provider's credentials on to ILHIE Direct and to log the provider into ILHIE Direct (which will remain in the background).
3. The login acknowledgements are passed back to the provider.
4. The provider selects the ILHIE Direct address of the receiver (this step can be postponed until after control has been passed to the ILHIE Direct portal in Step 8).
5. The provider selects a document or documents that are to be sent via ILHIE Direct.
6. The form or forms are presented to the provider to be filled in. Common fields between forms should only be filled in once.
7. The form is submitted to the BPWP where it is converted into an attachment (probably pdf) and placed in a repository where it can be picked up by the ILHIE Direct portal.
8. Control is transferred to the ILHIE Direct portal where the provider is already logged in.
9. The form or forms are retrieved from repository in step 7 and attached to a direct message. The provider is expected to provide a subject and short narrative at this point.
10. The secure message is sent on to its destination.
11. The message receipt is received by ILHIE Direct.

BHIP Sequence Diagram



Fields for Transition of Care (ToC)

Four Use Cases

There are four use cases that we are considering:

- Discharge Summary
- Discharge Instructions
- Consultation Request
- Consultation Summary

Each of these results in a different data entry form.

“Cover” Fields are Specified Separately

For the purpose of this specification, it might be helpful to think of the forms as having a “cover” part, like a fax cover sheet, and then a health information part. This approach makes the development of a specification a little bit easier, but the actual design of the product need not express a division of parts.

Fields for Transmission “Cover” Part

Cover Part for the “Discharge Summary” and “Discharge Instructions.”

Transmission Cover Info: Discharge Summary, Discharge Instructions	
Field	Date Type
Name of discharging facility	Text
Address of discharging	Text
Patient Name	Text
Medical Record Number	Text
Primary Care Physician	Text
Attending Physician	Text
Date of Admission	Date
Reason for Transfer/Discharge	Text
Date of Discharge	Date
Name of Accepting Entity	Text

Cover part for the “Consultation Request.”

Transmission Cover Info: Consultation Request	
Field	Date Type
Name of referring facility	Text
Address of referring facility	Text
Patient Name	Text
Medical Record Number (Referrer)	Text
Primary Care Physician	Text
Attending Physician	Text
Date of Request	Date
Reason for Request	Text
Consultant Facility	Text
Consultant Name	Text

Cover part for the “Consultation Summary.”

Transmission Cover Info: Consultation Summary	
Field	Date Type
Facility of Consultation	Text
Name of Consultant	Text
Patient Name	Text
Medical Record Number (Consultant)	Text
Date of Examination or Procedure	<u>Date</u>
Name of referring facility	Text
Medical Record Number (Referrer)	Text

Fields for Health Information Part

The health information fields for all four data-input forms are specified in one table, which follows. The mapping of fields to input forms is indicated in the column labeled “Doc”. The mapping uses the following shorthand.

Legend for “Doc” field:

DS Discharge Summary

DI Discharge Instructions

CR Consultation Request

CS Consultation Summary

all All the above

Health Information : Body of Forms			
Doc	Field	Text inferred	Date Type
DS	Reason for Discharge	Reason for discharge or transfer.	Text
DS, CR	Identifying Information	Eg. Patient is a 45- year- old African American female	Text
DS, CR	Level of Education	Developmental History (highest level of education, desire for continuing education, military experience, can patient read/write).	Text
DS, CR	Employment Status	Employed or unemployed or unknown	Radio
DS	Reason for Admission	Reason client requested treatment, patient's chief complaint, reason for admission.	Text
CR	Action Requested	Requesting (a) potential take-over of care, (b) potential ongoing maintenance, (c) evaluation of or procedure on patient (d) just a discussion between the health care providers.	Radio
CR, CS	Topic	Patient condition (or suspected condition) that is to be the subject of the specification	Text
DS, CR	Living Situation Prior to Admission	Residential History (includes last two years of housing prior to transfer; where, with whom patient lived, type of housing, and what led to loss of housing-family, public apartment, SRO, group home, CILA ETC.; also include place of birth, where raised and by whom)	Text
DS, CR	History of Hospitalizations	Hospitalizations in certain time span, types of hospitalizations	Text
DS	Session Count	Total number of sessions	Number
DS, CR	Services Received to Date	Treatment History (include any counseling or therapy received while in community or in hospital and patient's attitude and experience towards treatment; also include history of nursing home care, hospital care, and community care, group homes, etc): Psychopharmacology, psychotherapy, counseling, individual, group etc.	Text
DS, CR	History of Present Illness	Reason for Admission(focus on relationship between the patient's illness and level of functioning, include patient's subjective experience of his/her illness	Text

		and extent, nature, severity of patient's symptomology)	
DS, CR	Past Psychiatric History	History of Mental illness (include age of onset and description of symptoms, number psych of hospitalizations:	Text
DS, DI, CR, CS (all)	Substance use disorder diagnosis and History		Text
DS, CR	Personal History	Personal History (current marital status and marital history; spouses name, address, phone number of children and their occupations; other significant past present personal relationships; work history to include all past jobs, number of years at each job, reason for leaving each job, up to 5 years; legal history to include past convictions, misdemeanor, time spent in prison etc.)	Text
DS, CR	Family History	Family History (include information regarding resident's parents and siblings, such as medical problems, mental health problems, living arrangements; describe current family support, include history of domestic violence, physical/sexual abuse, neglect, foster care, traumas, separations and losses within family)	Text
DS, CR	History Medical Conditions	History of medical conditions and	Text
DS, DI, CR, CS (all)	Medications	List, dosage and frequency of present medication which include Medications used for: control of inappropriate behavior, reduction of and eventual elimination of the behaviors for which the medications are employed, and medication used to reduce, minimize and treat medical conditions.	Text
DS, DI, CR	Allergies	Types of allergies	Text

DS, CR, CS	Mental Status Examination	<p>The Mental Status Exam is the basis for understanding the patient's presentation and beginning to conceptualize their functioning into a diagnosis.</p> <p>Presenting Appearance including sex, chronological and apparent age, ethnicity, apparent height and weight (average, stocky, healthy, petite), any physical deformities (hearing impaired, injured and bandaged right hand)</p> <p>Basic Grooming and Hygiene, dress and whether it was appropriate attire for the weather, for a doctor's interview, accessories like glasses or a cane</p> <p>Gait and Motor Coordination (awkward, staggering, shuffling, rigid, trembling with intentional movement or at rest), posture (slouched, erect), work speed, any noteworthy mannerisms or gestures</p>	Text
DS	Tests - Beginning GAF/CGAS	If tests were performed at admission, provide score from "Global assessment of functioning" or "Children's Global Assessment Scale". (Indicate which, and score.) The date of testing is assumed to be approximately that given in "duration – begin date."	Radio & number
DS, CR	Tests - Most recent GAF/CGAS	If tests were performed recently, provide score.	Radio & number
DS, CR, CS	Diagnoses	<p>Axis I: This is the top-level diagnosis that usually represents the acute symptoms that need treatment; Axis 1 diagnoses are the most familiar and widely recognized (e.g., major depressive episode, schizophrenic episode, panic attack). Axis I terms are classified according to V-codes by the medical industry (primarily for billing and insurance purposes).</p> <p>Axis II: Axis II, is for personality disorders and developmental disorders such as mental retardation. Axis II disorders, if present, are likely to influence Axis I problems. For example, a student with a learning disability may become extremely stressed by school and suffer a panic attack (an Axis I diagnosis).</p> <p>Axis III: Axis III is for medical or neurological conditions that may influence a psychiatric problem. For example, diabetes might cause extreme</p>	Text

		<p>fatigue which may lead to a depressive episode.</p> <p>Axis IV: Axis IV identifies recent psychosocial stressors such as a death of a loved one, divorce, losing a job, etc.</p> <p>Psychosocial and Environmental Problems</p> <p>Axis V: Axis V identifies the patient's level of function on a scale of 0-100, (100 is top-level functioning). This is known as the Global Assessment of Functioning (GAF) Scale</p>	
CS	Encounter, Treatment, or Procedure Performed	Description of encounter (where appropriate.) Unilateral treatment action that was taken by consultant.	Text
CS	Acceptance of Responsibility	Where applicable, expression of decision to accept responsibility for either the patient's entire care or care of a specific condition or problem.	Text
CS	Plan for Coordinated Care	Plan for coordinated care. Includes any agreed to plan, or action steps. Reconciliation.	Text
CS	Pier Discussion	Summary of discussion, if any, between consultant and requester.	Text

DS, DI, CR, CS (all)	Summarized Plan of Treatment	<p>Each patient must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to—</p> <p>(i) Identifying the patient's needs, as described by the comprehensive functional assessments; and (ii) Designing programs that meet the patient's needs.</p> <p>In mental health, the treatment plan refers to a written document that outlines the progression of therapy. A treatment plan may be highly formalized or may consist of loosely handwritten notes.</p> <p><u>Examples</u></p> <p>List the relevant/ salient issues that may be appropriate to address on the Comprehensive Care Plan:</p> <p>(Verbal aggression, verbal abuse, alcohol/ substance abuse, poor ADLs(resistant to care and assistance from staff).</p> <p>List/identify the patient’s strengths, as the assessor identifies them that may assist in the development of Comprehensive Care Plan:</p> <p>(Patient is makes his/her needs known to staff. He/she has good insight into his/her alcoholism.)</p> <p>List/identify the patient’s weakness, as the assessor identifies them that may assist in the development of Comprehensive Care Plan:</p> <p>(Patient can be verbally abusive when redirected by staff. Patient requires supervised passes to ensure sobriety. Patient is not consistent with grooming and housekeeping).</p>	Text
DS, DI	Discharge Planning	<p>Patient’s goals and ambitions for the future, desire to live more independently or “normal” lifestyle.</p> <p>Describe patient’s attitude towards being discharged (per patient and per clinical observation):</p>	Text
DI, CS	Referrals, Follow up, and Continuing Care,	Referrals made. Appointments for follow up care. After care recommendations.	Text
DI	Revisit, Relapse,	Contact info for return visit should need	Text

	and Crisis Plan	arise. Recommendations should a relapse occur. Crisis planning.	
DI, CR	Goals and Progress	Patient's goals and ambitions for the future, desire to live more independently or "normal" lifestyle.	Text
DS, CR, CS	Informed Consent	<p>Informed consent is a legal document in all 50 states, prepared as an agreement for treatment, non-treatment, or for an invasive procedure that requires physicians to disclose the benefits, risks, and alternatives to the treatment, non-treatment, or procedure. It is the method by which a fully informed, rational patient may be involved in the choices about his or her health. Informed consent applies to mental health practitioners (psychiatrists, psychologists, etc.) in their treatment with their clients in generally the same way as physicians with their patients.</p> <p>Three conditions are necessary for autonomy:</p> <ol style="list-style-type: none"> 1) A person chooses and acts freely, 2) Deliberates rationally, and, 3) Does so according to his/her own authenticity. 	Check Box