jembi health systems

Linda Taylor <linda@jembi.org>

RHEA work group Clarification on RHIE indicator no. 3 (Number of clinical encounters [referral, physical, etc] saved per facility)

9 messages

Suranga Kasthurirathne <surangakas@gmail.com> 29 April 2014 07:50
Reply-To: rhea-work-group@googlegroups.com
To: rhea-work-group@googlegroups.com

Hi folks,

Dr. Paul and I have been going over the RHIE indicators list which was discussed during last week's RHIE call [0] I've been working on trying to update my initial indicator queries to reflect our latest decisions, and I want to list out certain arguments pertaining to indicator no. 3 (Number of clinical encounters [referral, physical, etc] saved per facility)

It occurred to us that different stakeholders may have a different definition of clinical encounters. For example, I know that many developers would consider a clinical encounter as an OpenMRS encounter. On the other hand, clinicians consider it as a single patient visit (etc. an 'OpenMRS visit').

During our initial study of the data, Dr. Paul and I also noticed some discrepancy in the persistence of encounters. Edits made to an encounter were being persisted as entirely new encounters, which raises some questions as to their measurement.

And also, given that we have different indicators to measure the number of return visits (1st, 2nd and 3rd visit), what dimension of visits are we trying to accomplish via this indicator ? is it
the measurement of the number of visits as divided into ANC, Referral and Delivery?

PS: As we clarify these points, i'm hoping to document them on the RHIE wiki in a more detailed manner.

Best regards,
Suranga

[0] https://docs.google.com/a/openmrs.org/spreadsheet/ccc?key=0AjkycZp8TCPOdHdkdHlpaGpXOHVpd3ZDOFRqbVpleUE&usp=drive_web#gid=0

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Best Regards,
Suranga

Paul Biondich <pbiondic@regenstrief.org> 29 April 2014 16:40

Reply-To: rhea-work-group@googlegroups.com
To: "rhea-work-group@googlegroups.com" <rhea-work-group@googlegroups.com>

Thanks Suranga, for the note.

I do think it's important to clearly identify what we mean by encounter. The clinical definition is surely: "one discrete interaction between a clinical worker and a client", but we should have Rwanda MoH sign off on this.

As the data currently exist, when a client has an initial visit, multiple "SHR encounters" are created in the HIE database, one for each form component of the interaction. Additionally, it's clear from our review that if a clinician edits one of these forms, another "SHR encounter" is created.

Those have to be consolidated down to a single, real world encounter, and so we'll have to write logic to focus on unique encounter dates per person. I believe that encounter dates (which is a database attribute of a SHR encounter) are good proxies for real world encounters, especially in outpatient, antenatal care settings.

-Paul
[Quoted text hidden]

Mead Walker <dmead@comcast.net> 29 April 2014 17:41
Reply-To: rhea-work-group@googlegroups.com
To: rhea-work-group@googlegroups.com

Hi,

I think Paul is quite correct. However, I would have expected something like “a period of time during which a person received treatment at a healthcare facility”

For example, if I go to the hospital to be treated as an inpatient, is that a single encounter or are there several encounters, one for each time I interact with a doctor, nurse or other clinician? At the end of the day, I think both perspectives are important, however it strikes me that, for most reporting purposes, my visit would be recorded as 1 inpatient encounter. Following on, if I go to the clinic for an outpatient visit, I might be evaluated by a nurse, see a doctor, and talk to the pharmacist when I receive my medication. One encounter? Or three?

Mead

From: rhea-work-group@googlegroups.com [mailto:rhea-work-group@googlegroups.com] **On Behalf Of** Paul Biondich
Sent: Tuesday, April 29, 2014 10:41 AM
To: rhea-work-group@googlegroups.com
Subject: Re: RHEA work group Clarification on RHIE indicator no. 3 (Number of clinical encounters [referral, physical, etc] saved per facility)

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[Quoted text hidden]

Paul Biondich <pbiondic@regenstrief.org> 29 April 2014 18:10
Reply-To: rhea-work-group@googlegroups.com
To: "rhea-work-group@googlegroups.com" <rhea-work-group@googlegroups.com>

I think that's even more complete of a definition, Mead... thanks.

-Paul

PS: good to "see you"!
[Quoted text hidden]

Mead Walker <dmead@comcast.net> 29 April 2014 18:23
Reply-To: rhea-work-group@googlegroups.com
To: rhea-work-group@googlegroups.com

It is always feels great to contribute to this effort. I have been away.

Mead

From: rhea-work-group@googlegroups.com [mailto:rhea-work-group@googlegroups.com] **On Behalf Of** Paul Biondich
Sent: Tuesday, April 29, 2014 12:10 PM

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Derek Ritz <derek.ritz@gmail.com> 29 April 2014 18:23
Reply-To: rhea-work-group@googlegroups.com
To: "rhea-work-group@googlegroups.com" <rhea-work-group@googlegroups.com>

Hi all.

There may be a natural evolution in our eHealth transactions that will see the premise of "encounter" become more closely aligned with our HIE traffic content and when this traffic occurs. There is a longstanding debate in eHealth circles about "message-based" vs. "document-based" transactions. One of the truths is that a document-based traffic pattern will tend to align closely with the on-the-ground definition of "encounter".

If, at some future time, we are sending an antepartum summary (APS) "document" to the HIE, it will encapsulate the content that is, today, captured on multiple forms and submitted in multiple messages. If a discharge summary is submitted to the HIE (using Mead's excellent example), it will encapsulate in a single "document" the various activities during the hospital stay.

IHE profiles generally embrace a document-centric posture. If we begin to slowly migrate in this direction, over time, some of these present issues will "sort themselves out". :-)

Warmest regards,

Derek.
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--

Derek Ritz

[Quoted text hidden]

Mead Walker <dmead@comcast.net> 29 April 2014 21:43
Reply-To: rhea-work-group@googlegroups.com
To: rhea-work-group@googlegroups.com

Hello Derek, and group members.

It is not clear to me why "a document-based traffic pattern will tend to align closely with the on-the-ground definition of "encounter"."

With regard to the debate that Derek refers to, I would re-phrase it as data exchange via discrete data as opposed to data exchange via data in human readable blocks. I do think each paradigm has its merits, but would offer the thought that, if you want to do reporting or decision support, you would like to load the content into a database as discrete elements.

Mead

From: rhea-work-group@googlegroups.com [mailto:rhea-work-group@googlegroups.com] **On Behalf Of** Derek Ritz
Sent: Tuesday, April 29, 2014 12:23 PM

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Derek Ritz <derek.ritz@gmail.com> 29 April 2014 21:58
Reply-To: rhea-work-group@googlegroups.com
To: "rhea-work-group@googlegroups.com" <rhea-work-group@googlegroups.com>

Hi all.

Mead -- I couldn't agree more. If you want to be able to leverage the data it needs to be in computable, discrete bits. My suggestion was about how these bits could be conveyed and packaged... I didn't at all mean to suggest that we should favour mere eyeball-to-eyeball interoperability over "semantic" interoperability.

My comment about "alignment" simply refers to the fact that a document metaphor tends to line up with the places where paper-based forms would typically be used to capture information about care workflows.

Great to see you back, Mead. We've missed your insights... and we've missed you!

Warmest regards,

Derek.
[Quoted text hidden]

Dawn C. Seymour <dawn@openmrs.org> 30 April 2014 10:20
Reply-To: rhea-work-group@googlegroups.com
To: rhea-work-group@googlegroups.com

Hi Everyone,

Duplicate Encounters & the Definition of Encounter

> **@Suranga** - Do you have any data that shows a) a high-level view of the number of duplicate encounters from each health centre and b) a detailed view as to which specific encounters are most frequently duplicated at each health centre?
>
> While nearly all of the health centres follow the same clinical workflow segments in the same patterns and provide the same clinical services, I'm curious to look at the data for each health centre here and see what kind of story we find. Have we created numerous duplicates since the start of the implementation or is this a more recent occurrence? Are a few health centres showing more duplicates than others or is it a trend across all health centres? Could changes in workflow be an underlying factor for creating duplicate encounters or could it be something such as hitting "save" multiple times because the internet connection is slow? Is there in fact different information between duplicate encounters (1st encounter says 30C for temp and the second says 37C for temp)? These are a few of the immediate questions that come to my mind that I am curious to know the answers to. Perhaps what we find may contribute to the discussion with the Rwanda MOH about how an encounter is defined.

Indicators to Measure Return Visits

> Short answer: I advise that based on the WHO standard for the 4 ANC visits, that we measure return visits based on the completion of the ANC Physical form given that it contains specific measurements taken at each visit which show the progression of the pregnancy - including the 4th visit during the 9th month - and captures information on complications.
>
> Considerations: One of the limitations the WHO mentions in this same area is that "receiving antenatal care during pregnancy does not guarantee the receipt of all the interventions that are effective in improving maternal health." So defining what interventions (testing, vaccinations, screening for complications, etc) constitute an "ANC return visit" may be a larger discussion for Dr. Richard and the Maternal and Child Health (MCH) Department to have to ensure we are all on the same page.

Sincerely,

Dawn C. Seymour, MPH
+250 78 683 0966
Skype: dawn.courtney.smith
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