[Yesterday 14:42] Stephen Chu

Is "pregancy status" = "pregnancy | obstetric history"?

[Yesterday 14:43] Lisa Kalman

Pregnancy status and obstetric history should be sepparate items

like 3

[Yesterday 14:48] Jacqui Rhodes

Should Vaccination administered be in R1 when many of them are uploaded to the A.I.R.?

[Yesterday 14:48] Sarah Dibley

Key Biomarkers - seem to be missing key commonly ordered tests i.e. FBC/LFT that aren't contestable as 'might not be needed'

[Yesterday 14:48] Michael Bainbridge (MAC)

Absolutely Stephen..

[Yesterday 14:49] Michael Bainbridge (MAC)

(and Ruben)

[Yesterday 14:51] Loya, Philip

Procedure clinical indication isn't something that is captured discretely in my system -- it's clear from notes, referrals, and other parts of the chart etc. but not documented explicitly against the procedure concept.   Happy for it to stay as long as the assumption is required IF you support it

[Yesterday 14:55] Loya, Philip

Other tobacco assessment data would be other observation elements, as Vince suggests -- so if we want to have more than just the status, we'd need to call that out

[Yesterday 14:56] Loya, Philip

As some point we will need to crosswalk between the clinical concepts and the technical concepts so that we ensure that we're talking the same language.   Right on Vince and Kate!

[Yesterday 14:56] Chris Moy (AMC)

R1 Initial Biomarkers

[Yesterday 14:57] Sarah Dibley

key biomarkers - maybe it would be useful to determine the most commonly ordered tests overall across all specialties, rather than base this on one particular risk assessment

[Yesterday 14:58] Loya, Philip

**Chris Moy (AMC) (External)**

R1 Initial Biomarkers

This name won't make sense to most technical folks who have FHIR experience.

[Yesterday 15:01] Jo Wright (Guest)

Yes the systems generally support life status, which cease notifications and recalls etc..

[Yesterday 15:01] Lisa Kalman

**Sarah Dibley**

key biomarkers - maybe it would be useful to determine the most commonly ordered tests overall across all specialties, rather than base this on one particular risk assessment

Cardiovascular disease is the biggest killer of people in Australia, defining these will have significant impact on the health of all Australians. These are also required for definition to enable health providers to comply with latest standards and clinical recommendations

[Yesterday 15:02] Chris Moy (AMC)

Can call it Key Biomarkers but explain clearly it when goes out to consultation that this is R1 starting batch. It's clear that we have to cater for those who in the know about FIHR but also  those that are coming from outside and wondering why we don't have "biomarkers" covering their area

[Yesterday 15:03] Vincent McCauley (Guest)

Cancer is the second biggest killer and we have nothing that specifically supports that. This would be better done a ]s a specific example set of observation

like 2

[Yesterday 15:07] Dr. Patrick Fergal McSharry (Guest)

Sorry , I am just so new to this in an Australian Context . However I have had a "ton" of exposure as a Family Physician and GP in N. America - Clevland Clinic Cerner (and transferred that  to the A.D. U.A. E. I) AMIA member while in the States also My questions is not specific at all . It is a General Question To go with my GP NT Experience .)so... Here my main concern is how I can in a Primary Care Large Private GP in the NT can go have some Interoperability between Best Practice or other P.C.  EHR (other General Practices ) but also some access to the Secondary Care Systems (without having to sign up to their system ) I find My Health very much a "Patient Portal "

[Yesterday 15:07] Vincent McCauley (Guest)

RCPA already have a terminology set for the most commonly ordered pathology which reflects the 3 year+ PITUS program

[Yesterday 15:09] Michael Bainbridge (MAC)

Definitely familiar Heather Leslie

[Yesterday 15:10] Roy Mariathas

I find the use of the word 'risk' interesting here. What are the implications (good/bad) of removing this?

[Yesterday 15:12] Roy Mariathas

Looking at the trees, it seems like risk should sit under the umbrella of 'adverse reactions'

[Yesterday 15:13] Chris Moy (AMC)

The aim is to core to core to get something over the line which is doable- so that we can build onto it

like 1

[Yesterday 15:14] Jacqui Rhodes

I need to drop off, thanks everyone.

like 1

[Yesterday 15:17] njferris (Guest)

Could "manifestations" be tiered ?

[Yesterday 15:19] Michael Bainbridge (MAC)

A structure to manifestations is implied by the SNOMED structure currently - the 'clinical manifestations' reference set for instance allows 'RASH' OR considerably more detail... The set is 743 items I think

[Yesterday 15:20] Averil Tam

**njferris (Guest)**

Could "manifestations" be tiered ?

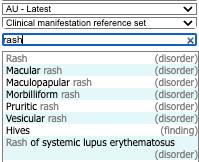
When the risk/severity is captured in later releases, this may assist to tier/triage how the ADRs and manifestations are displayed?

[Yesterday 15:20] Smith, William (Health)

Risk is a prospective concept, this is appropriate but it is an inference which requires clinical curation. However these fields are often used as a retrospective record. Not the same thing

[Yesterday 15:21] Michael Bainbridge (MAC)

739  - I added 5 !



1f4a1\_electriclightbulb 1

[Yesterday 15:21] Ong, Stephanie [AU-AU]

The current valueset binding  for *AllergyIntolernace.code* addresses drug classes (as I understand it)

[Yesterday 15:22] Loya, Philip

Clinicians in my system could either enter the allergy against a specific penicillin OR the penicillin class.  (My clinical decision support recognises both...)  There is no capability to further refine a penicillin class if you choose to document the allergy at the class level.  You can remove the class and then document the specific penicillins once you know more, though.

[Yesterday 15:22] Ong, Stephanie [AU-AU]

The Substance foundation reference set contains common grouper/therapeutic class concepts.

like 1

[Yesterday 15:23] Vincent McCauley (Guest)

Medication class is also important in considering other potential allregies to additional class members

[Yesterday 15:23] Chris Moy (AMC)

Important point to sort out Averil thanks

like 1

[Yesterday 15:23] Loya, Philip

(Point being that there is no secondary check / entry if you document at a class level)

[Yesterday 15:27] Dr. Patrick Fergal McSharry (Guest)

Just a "Houskeeping " question please . where are we on the agenda are we still on "Adverse Reaction Risk " ?

like 1

[Yesterday 15:28] Loi, Kylynn (H&B, Herston)

yes, still on adverse reaction risk

[Yesterday 15:29] Jo Wright (Guest)

I think an accurate and complete adverse reaction risk is a higher priority than some other elements suggested for R1

[Yesterday 15:29] Dr. Patrick Fergal McSharry (Guest)

I thought this was for Interoperability mainly in Primary Care ?

[Yesterday 15:29] Janette Gogler

this is about sharing data and should not be complicated as we always re validate it with the patient. /carer  .  We also must consider the accuracy of the data in the local EMR /CIS .

like 1

[Yesterday 15:30] Dr. Patrick Fergal McSharry (Guest)

WE are the ones who code the Diagnosis (eg ICD ) (Primary Care. Agree totally with Chris , seems we are getting hung up on specifics?

[Yesterday 15:30] Loya, Philip

**Dr. Patrick Fergal McSharry (Guest)**

I thought this was for Interoperability mainly in Primary Care ?

Yes an no -- we're talking about the core and the first use cases of the core are proposed to be International Patient Summary and eRequesting of Diagnostics.   That will include Primary Care, but does not exclude Hospitals, Specialists, Allied Health, Community, etc.

like 1

[Yesterday 15:31] Vincent McCauley (Guest)

I'm not sure why we are considering a very large terminology set for adverse reaction (which vendors and existing state registries will find difficult to support) but a very restricted terminology set for observation

like 1

[Yesterday 15:34] Dr. Patrick Fergal McSharry (Guest)

**Loya, Philip**

Yes an no -- we're talking about the core and the first use cases of the core are proposed to be International Patient Summary and eRequesting of Diagnostics. That will include Primary Care, but does not exclude Hospitals, Specialists, Allied Health, Community, etc.

Hi Philip. I get that and still an ABFM Member , I  do like that we are looking at the US example . However in the States (where there is Horizontal and Vertical Integration it's a bit easier) , Primary. Secondary and Tertiary already in the same system But always Primary Care Driven)

[Yesterday 15:37] Dr. Patrick Fergal McSharry (Guest)

I like what David is saying right now . We in " GPLand " like it pretty simple

[Yesterday 15:38] Vincent McCauley (Guest)

For problem/diagnosis there needs to be a start date AND end date otherwise it is impossible to now if this is a current clinical issue or was an issue when specific other cliinical information was obtained

[Yesterday 15:38] Jo Wright (Guest)

Problem/diagnosis is a category which is most useful in both primary and tertiary care

[Yesterday 15:38] Loya, Philip

**Dr. Patrick Fergal McSharry (Guest)**

Hi Philip. I get that and still an ABFM Member , I do like that we are looking at the US example . However in the States (where there is Horizontal and Vertical Integration it's a bit easier) , Primary. Secondary and Tertiary already in the same system But always Primary Care Driven)

That might be a convo for another time -- I'm originally from the US but have lived in Australia for 13+ years.  So very much see the similarities and differences between the two.

My main point, which is what I've struggled with, is that Core is just a generic concept to create the building blocks that we'll use to handle IPS or eRequesting or potentially Primary Care Transfer (if IPS isn't used instead)

[Yesterday 15:39] Jackie O'Connor

I agree date is important

[Yesterday 15:39] KK Cheung (Guest)

Yes date critical or at least active/non active status

[Yesterday 15:39] Sarah Dibley

Agree, date of dx is important

[Yesterday 15:39] Loya, Philip

For problems / diagnoses, we need to identify items which are acute for this visit vs. longer running.   Dates may be important or a proxy but needs to be clear.   If I had a fractured wrist 10 years ago, hopefully I don't have it still today...

[Yesterday 15:40] David Wiebe

Lifestyle

[Yesterday 15:41] Sanjeed Quaiyumi

Wouldn't that be dietary preferences or lifestyle choices?

[Yesterday 15:41] Oliver Frank (Guest)

'Vegetarian' really belongs in Diet or Nutriono

[Yesterday 15:41] Chris Moy (AMC)

Interesting point Rob!👍

[Yesterday 15:42] Smith, William (Health)

Vegetarian not a problem, nutritional deficiency is a problem

like 1

[Yesterday 15:43] Jackie O'Connor

as a clinician who works with people with disabilities and being a consumer with Type 1 diabetes I would prefer not to have the word 'problem' against my diagnosis too

like 1

[Yesterday 15:44] Dr. Patrick Fergal McSharry (Guest)

**Loya, Philip**

That might be a convo for another time -- I'm originally from the US but have lived in Australia for 13+ years. So very much see the similarities and differences between the two. My main point, which is what I've struggled with, is that Core is just a generic concept to create the building bl…

Thanks Phil . (I'm from the Emerald Isle and only her x 3 yrs ) Definitely would love a "convo " on where we're at here as I'm only here in the NT 4 years ("keeping my head above water" till now )  and not using all my experience from the other Jurisdictions until now as I have  at last am in a position to start to " sail my boat" let's say, hence my involvement here.

[Yesterday 15:44] Roy Mariathas

Looks good!

[Yesterday 15:45] Roy Mariathas

To add to Rob I would say specialist as well (not R1 though)

like 1

[Yesterday 15:45] Ong, Stephanie [AU-AU]

thanks all; I need to drop off now.

[Yesterday 15:45] Loya, Philip

**Dr. Patrick Fergal McSharry (Guest)**

Thanks Phil . (I'm from the Emerald Isle and only her x 3 yrs ) Definitely would love a "convo " on where we're at here as I'm only here in the NT 4 years ("keeping my head above water" till now ) and not using all my experience from the other Jurisdictions until now as I have at last am in a pos…

Perfect, happy to chat -- my e-mail is [philip.loya@oracle.com](mailto:philip.loya@oracle.com)

[Yesterday 15:46] Oliver Frank (Guest)

Is Vaccine name the brand name, which varies in different countires)  or the generic name?

[Yesterday 15:46] Dr. Patrick Fergal McSharry (Guest)

**Loya, Philip**

Perfect, happy to chat -- my e-mail is philip.loya@oracle.com

Thank you Phil.

[Yesterday 15:47] Vincent McCauley (Guest)

I think batch number is important

like 1

[Yesterday 15:47] Loya, Philip

For noting with Vaccine -- we'll need to consider not having sequence number as compulsory.   The AIR arbitrarily forcing sequence numbers causes some major issues

[Yesterday 15:47] Loya, Philip

Would not recommend batch number -- that's already in the AIR

[Yesterday 15:48] Averil Tam

**Vincent McCauley (Guest)**

I think batch number is important

It is, plus it is captured in all systems I have used so far

[Yesterday 15:48] Loya, Philip

And any recall would be managed by the immunising org, not so much who you pass the data to

[Yesterday 15:48] Rob Hosking (Guest)

Batch number is required under AIR notifications

[Yesterday 15:48] KK Cheung (Guest)

**Jackie O'Connor**

as a clinician who works with people with disabilities and being a consumer with Type 1 diabetes I would prefer not to have the word 'problem' against my diagnosis too

Agree. We are moving towards a model of supporting health and wellbeing. Would definitely prefer not to utilise "problem"

[Yesterday 15:48] Vincent McCauley (Guest)

For it to go in AIR it needs to come from the clinical record

[Yesterday 15:48] njferris (Guest)

re procedure name - ? subcategorise by group - surgical/drug therapy/imaging/biochemical analysis etc

[Yesterday 15:49] Loya, Philip

Would agree with batch not being in R1 -- and would need to be optional

[Yesterday 15:53] David Wiebe

thanks Heather! Great work

[Yesterday 15:55] Janette Gogler

great work ..

[Yesterday 15:55] Jo Wright (Guest)

Thanks Team!

[Yesterday 15:55] Rob Hosking (Guest)

Thank you Heather

[Yesterday 15:55] Dr. Patrick Fergal McSharry (Guest)

Great work y'all. I see how it works now I think .  Chris explained thatw ell.

like 1

[Yesterday 15:55] Dr. Patrick Fergal McSharry (Guest)

Thank you.

like 1

[Yesterday 15:55] Oliver Frank (Guest)

Thanks everybody

[Yesterday 15:56] Bharti Saroha

Thank you

[Yesterday 15:56] Chris Moy (AMC)

I have my swift tickets!

like 3 heart 3

[Yesterday 15:56] Roy Mariathas

Thank you!!