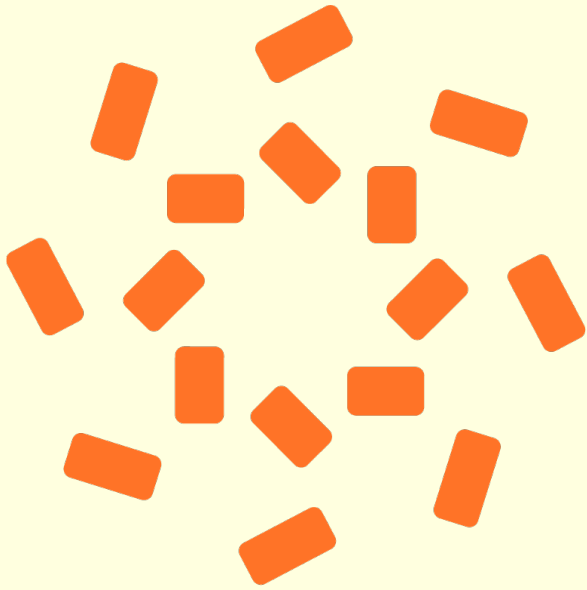# Pre meeting slide pack

Sparked

HL7 FHIR

Sparked Clinical Content Design Group
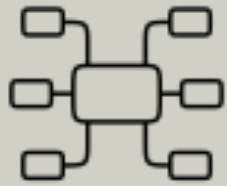
Tuesday 5 December Meeting

Online

What is AU Core and Australian Core Data set for Interoperability (AUCDI)?

CDG is here

AU CDI — Specifies *"WHAT"* **clinical information** (and corresponding data elements and terms) should be included when sharing information supporting patient care
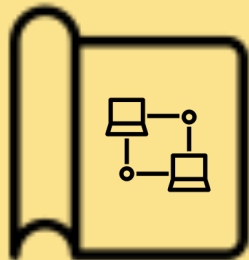
TDG is here

AU Core — Specifies *"HOW"* the core set of data (above) and information should be **structured, accessed** and **shared** between systems
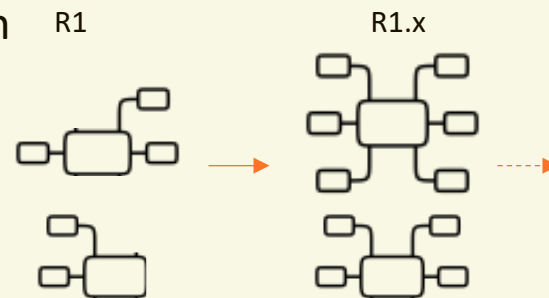
Sparked
HL7 FHIR

Sparked: AUCDI

Key outcome is "core of the core"

Start small and grow iteratively

- No simple "undo" – impact of change can be high
- Data elements can be added to over time
  - Work through backlog
  - Add more use cases
  - More functionality available

R1   R1.x

Stick with our design principles

Align and leverage work internationally were possible
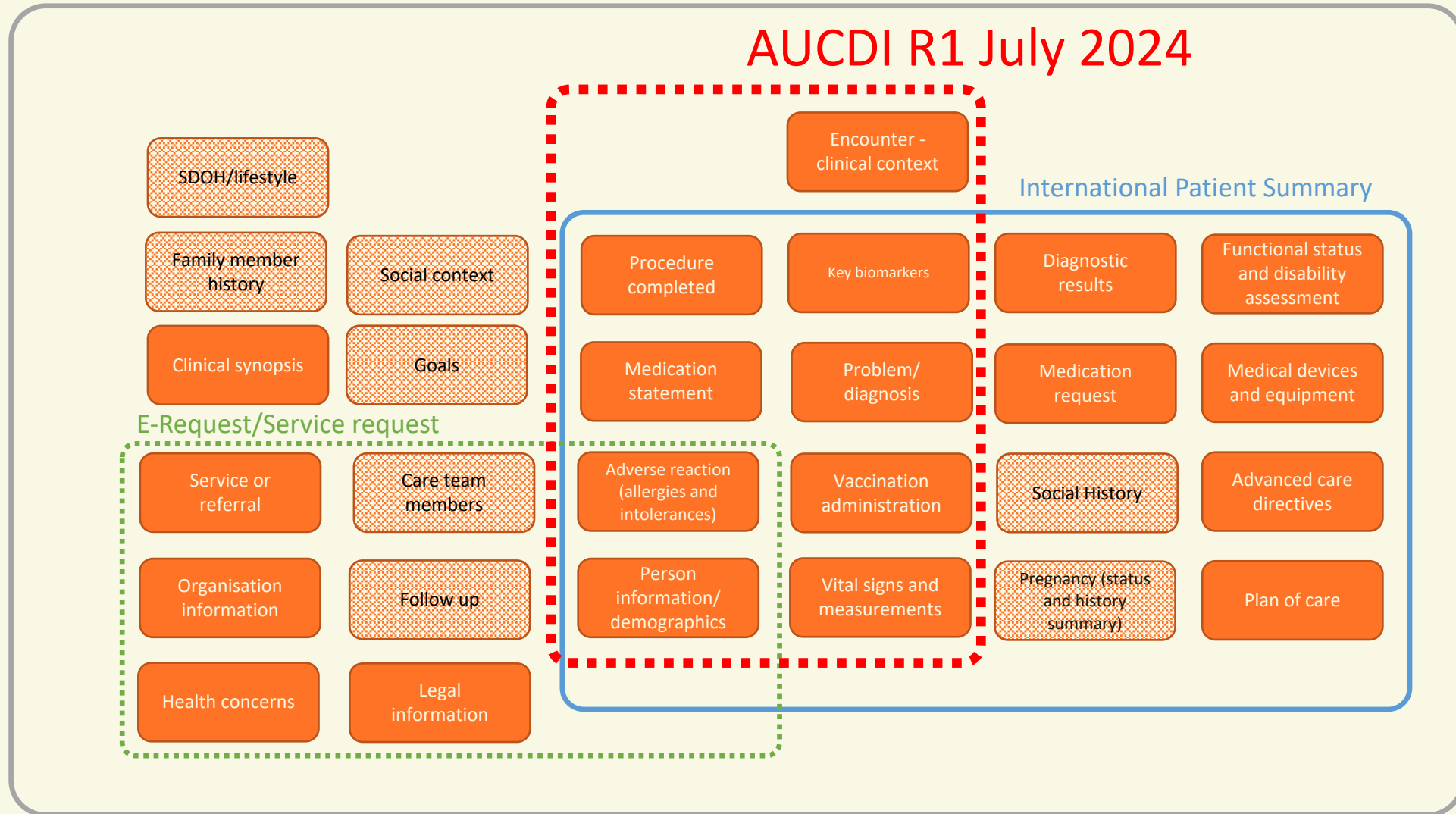
- Where we differ, need to understand the impact

"From little things, big things grow"

Core Draft Principles of Data Set Design

1 — Single entry, single development - multiple use and reuse

2 — Supports patient centred care - driven by a clinical quality and safety use case

3 — Reduce duplication of effort, not collecting of data for data's sake

4 — Driven by primary clinical data use not secondary data use needs

5 — Supports best practice care, clinical guidelines and clinician workflow

6 — Systems can support now or with minimal effort, supporting a strategic roadmap with an agile iterative process

7 — Leverage agreed national health data standards

8 — Involve and consider all healthcare modalities

Sparked
HL7 FHIR

AUCDI – Updated Draft Scope (Dec 2023)

Potential AUCDI R2 candidates

AUCDI R1 July 2024

International Patient Summary

E-Request/Service request

SDOH/lifestyle	
Family member history	Social context
Clinical synopsis	Goals

Encounter - clinical context	

Procedure completed	Key biomarkers
Medication statement	Problem/diagnosis
Adverse reaction (allergies and intolerances)	Vaccination administration
Person information/demographics	Vital signs and measurements

Diagnostic results	Functional status and disability assessment
Medication request	Medical devices and equipment
Social History	Advanced care directives
Pregnancy (status and history summary)	Plan of care

Service or referral	Care team members
Organisation information	Follow up
Health concerns	Legal information

Sparked
HL7 FHIR

Proposed changes to scope of R1

- Clinical synopsis moved to "To Do List"

- Pregnancy status moved to "To Do List"

- Observations renamed to "Key Biomarkers" – scope limited to cardiovascular risk calculator for R1
    - HDL
    - LDL
    - Total Cholesterol
    - Trigs
    - HbA1c
    - eGFR
    - uACR

Proposed Candidate for Draft R1

Problem/Diagnosis
- Problem/diagnosis name
- Body site/laterality
- Status
- Comment

Procedure completed
- Procedure name
- Body site/laterality
- Clinical indication
- Date performed
- Comment

Vaccination administered
- Vaccine name
- Sequence number
- Date of Administration
- Comment

Adverse reaction risk
- Substance name
- Manifestation/s
- Comment

Medication statement
- Medicine name
- Strength
- Form
- Dose
- Route of administration
- Dose frequency
- Duration
- Instructions
- Clinical Indication
- Comment
- Status
- Start date
- Long term indicator

Gender
- Sex assigned at birth
- Gender identity
- Pronouns

Tobacco smoking
- Overall Status

Key biomarkers
- HDL
- LDL
- Total Cholesterol
- Trigs
- HbA1c
- eGFR
- uACR

Vital signs
- Blood pressure
  - Systolic
  - Diastolic
- Pulse
  - Rate
  - Rhythm*
- Body temperature
- Respiration
  - Rate

Measurements
- Height/length
- Body weight
- Waist circumference

Encounter – clinical context
- Reason for encounter
- Type of encounter

Sparked
HL7 FHIR

AUCDI

- What level of information should we include?

DATA CLASS

Allergies and Intolerances

Represents harmful or undesirable physiological responses associated with exposure to a substance.

DATA ELEMENT	APPLICABLE STANDARD(S)
Substance (Medication)	• RxNorm, January 6, 2020 Full Release Update
Substance (Drug Class)	• SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, September 2019 Release
Reaction	• SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, September 2019 Release

UK Professional Records Standards Body (PRSB)

Diabetes Record Information Standard
Version 1.0

| | 'How to' Guide | Search By Item 🔍 | Filter By ▾ ⓘ | Reset all |

MRO ⓘ	Name	Description	Value Sets ⓘ	Implementation Guidance ⓘ	Information Type ⓘ	Cardinality ⓘ
M	▸ Person demographics	The person's details and contact information.	-	This section contains the person's... **Read more >**	Record	1 ... 1
M	▸ GP practice	Details of the person's GP practice.	-	This section contains details of t... **Read more >**		1 ... 1

AU Primary Care Quality Design Foundations – Practice to Practice Use case

Data elements

Substance	Description	Identification of a substance, or substance class, which is considered to put the individual at risk of an adverse reaction event. *Both an individual substance and a substance class are valid entries in 'Substance'. A substance may be a compound of simpler substances, for example a medicinal product.*
	Element occurrence	Mandatory, single occurrence
	Data type	Codeable concept
	Value set	This ADHA value set contains a broad set to support the recording of agents that may be responsible for causing adverse reactions. This set includes all AMT product concepts as well as SNOMED CT-AU substances such as chemical, material and dietary substances
	Examples	111088007 | Latex | 256259004 | Pollen | 102263004 | Eggs (edible) | 256349002 | Peanut | 373270004 | Penicillin | 3738011000036101 | Amoxil |
	Alias	Agent, Class, Product

Sparked
HL7 FHIR

AUCDI

- Publish a logical data model
  - Similar to PCDQ
  - More than USCDI, closer to PRSB
  - Recommend terminology value sets where appropriate

- Will include
  - Name
  - Description
  - Element occurrence
  - Data type
  - Recommended standard code systems and value sets*
  - Alias*
  - Considerations*
 - Examples*

* Where appropriate or necessary

**Sparked**
HL7 FHIR

Into the data model...

Adverse reaction risk

Details about a single substance (or class of substance) which, on exposure, may put the individual at risk of an adverse reaction.

- Includes, but not limited to, allergy and intolerance

- Scope:
  - Medication
 - Food
  - Environmental, including latex and bites/stings

Adverse reaction risk
- Substance name
- Manifestations
- Comment
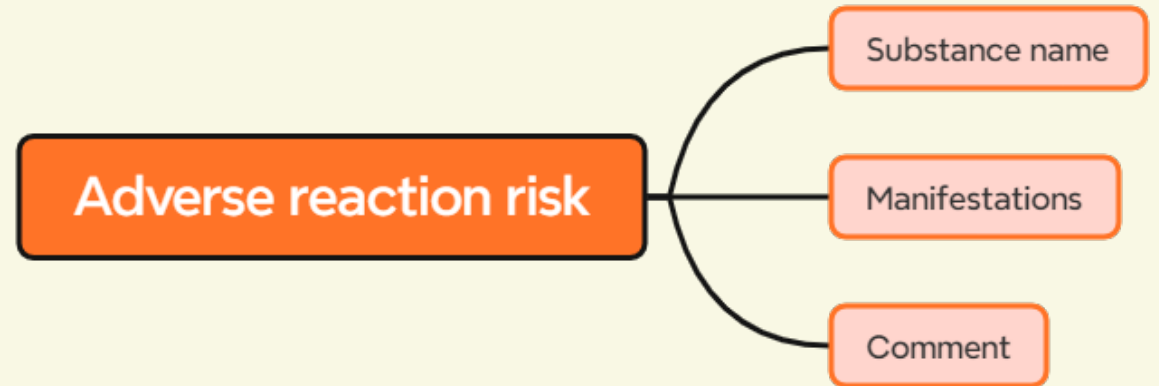
Problem/Diagnosis

Details about a single identified health condition, injury, disability or any other issue which impacts on the physical, mental and/or social well-being of an individual.
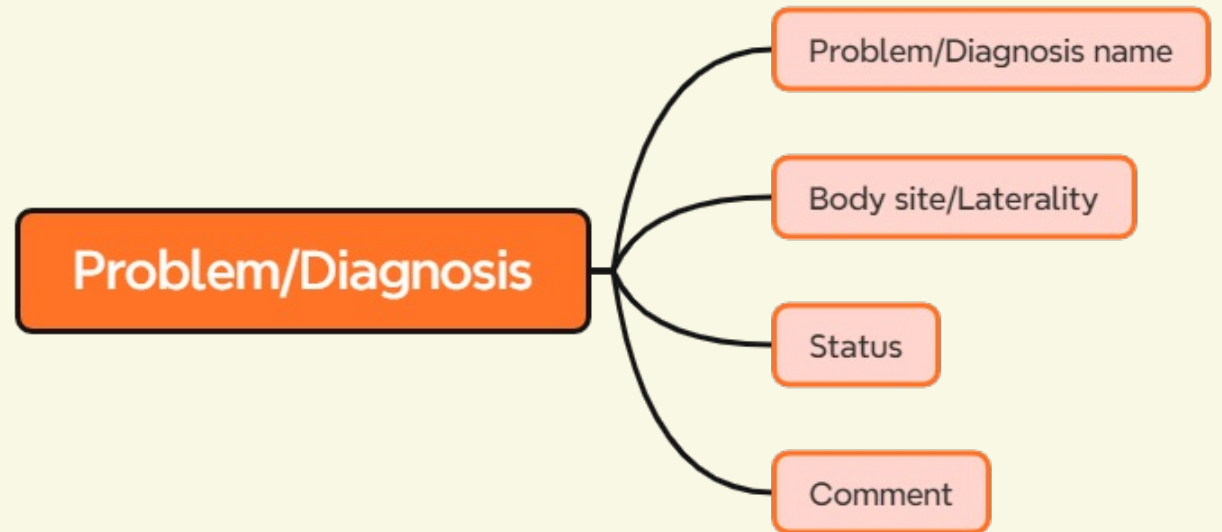
Procedure completed

Details about a single clinical procedure carried out for screening, investigative, diagnostic, curative, therapeutic, evaluative or palliative purposes.

Procedure completed
- Procedure name
- Body site/laterality
- Clinical indication
- Date performed
- Comment
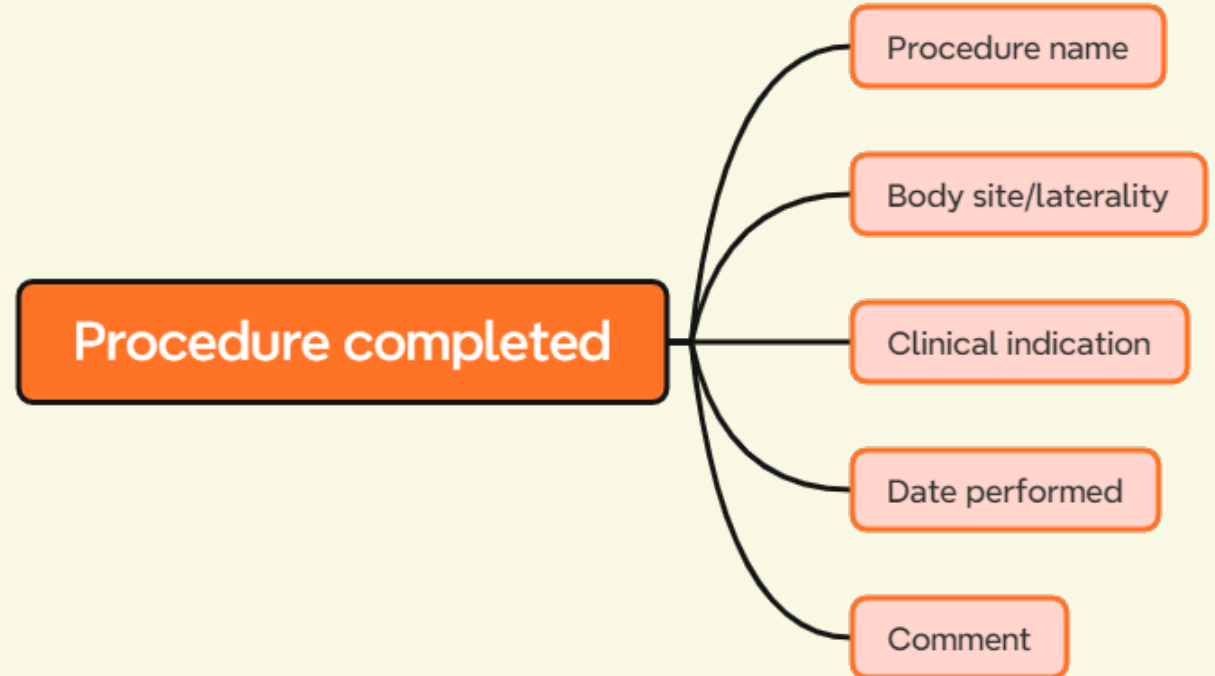
Vaccination administered

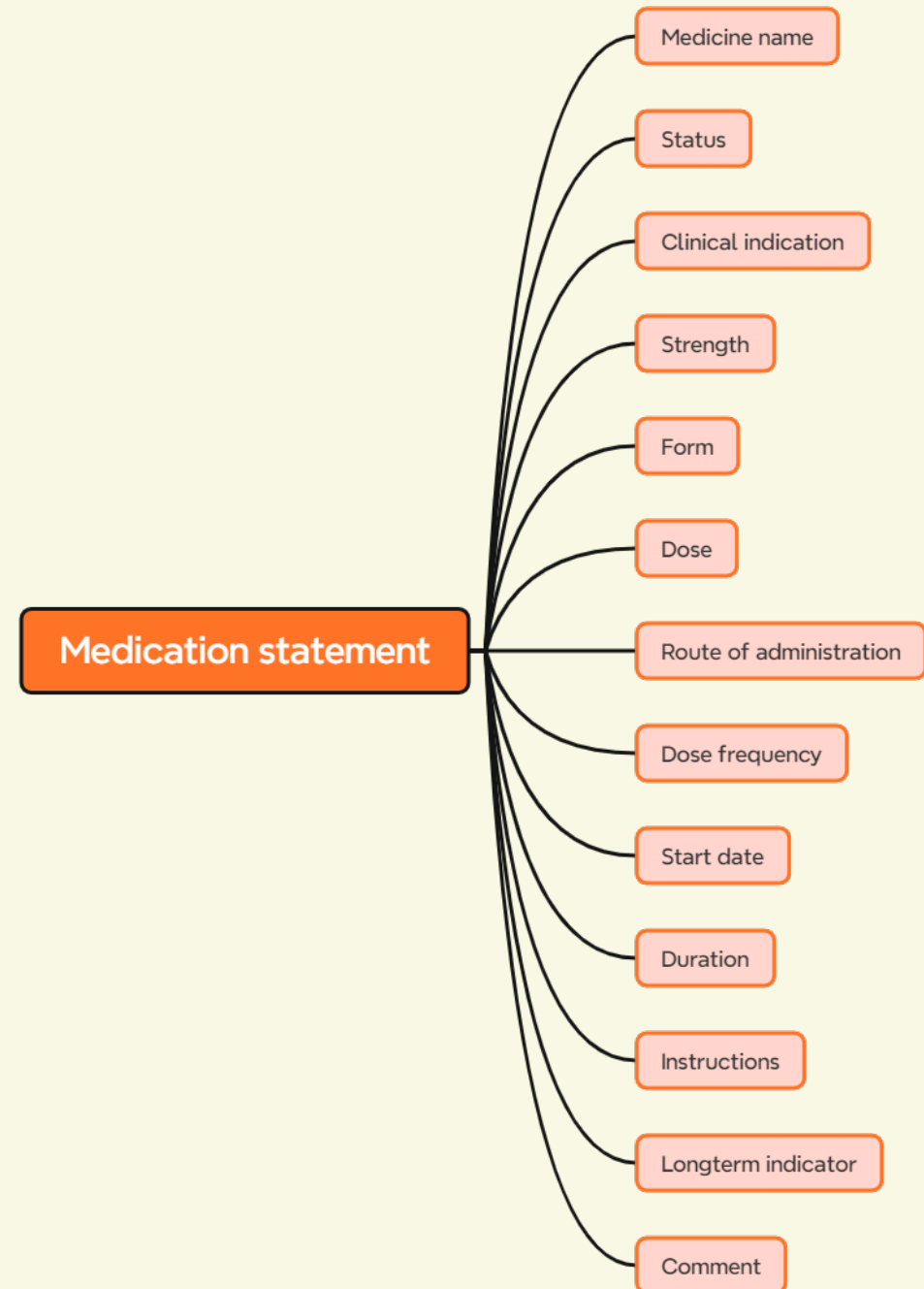Details about a single vaccine that has been administered to the individual.
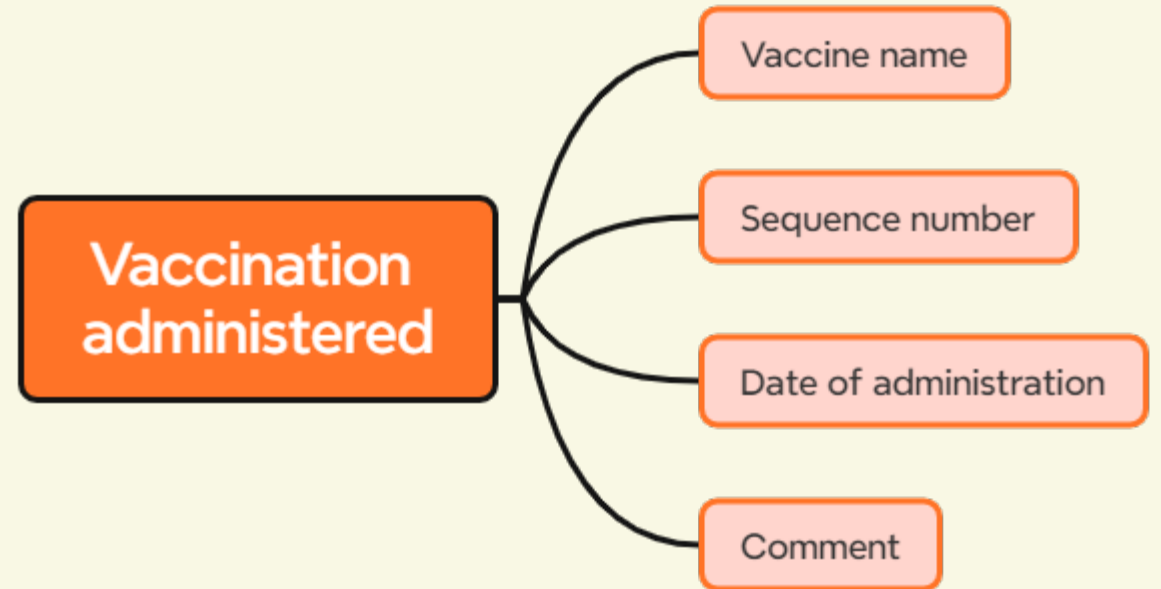
End of agenda for 5 December meeting

Next topics for 17 January meeting

Medication statement

Details about a medicine, nutritional product or other therapeutic item that is currently being taken or used by the individual, including items that are prescribed or obtained over the counter.

Medication statement
- Medicine name
- Status
- Clinical indication
- Strength
- Form
- Dose
- Route of administration
- Dose frequency
- Start date
- Duration
- Instructions
- Longterm indicator
- Comment

Gender

- Sex assigned at birth
  - The sex of the individual determined by anatomical characteristics observed and registered at birth.
- Gender identity
  - The individual's internal perception of their own gender.

Gender
- Sex assigned at birth
- Gender identity
- Pronouns
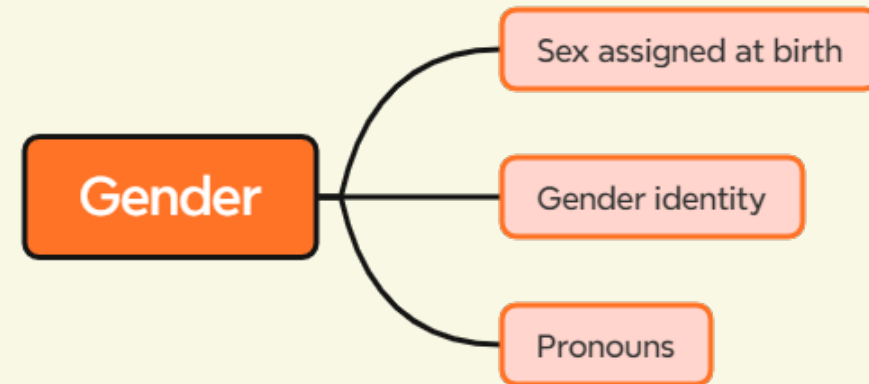
Tobacco smoking

Details about the tobacco smoking habits of the individual.

- Statement about current smoking habits for all types of tobacco.

- Proposed value set: Never, Current, Former.

Sparked
HL7 FHIR

Encounter – clinical context

- ## Reason for encounter
  - The reason for initiation of any healthcare encounter or contact by the individual who is the individual.
  - Proposed value set combines clinical and administrative values
    - 'Presenting complaint' (or similar) with a value set comprising symptoms and signs, for example 'shortness of breath' or 'vomiting'; and
    - 'Reason for attendance (or similar) with a value set comprising terms that reflect administrative, billing or funding reasons, for example 'pre-employment medical' or 'routine immunisation'.

- ## Type of encounter
  - The modality through which the encounter occurred or was conducted

Encounter
Clinical context only

Reason for encounter

Type of encounter
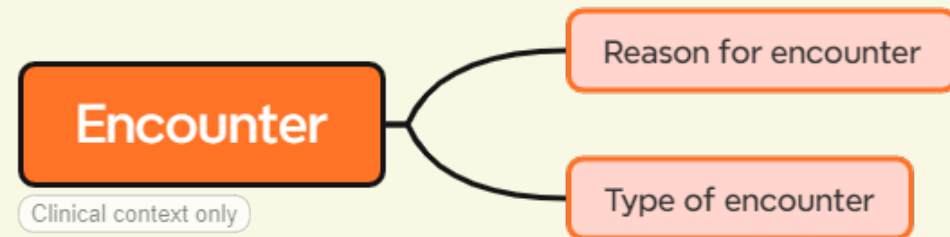
Vital signs and Measurements
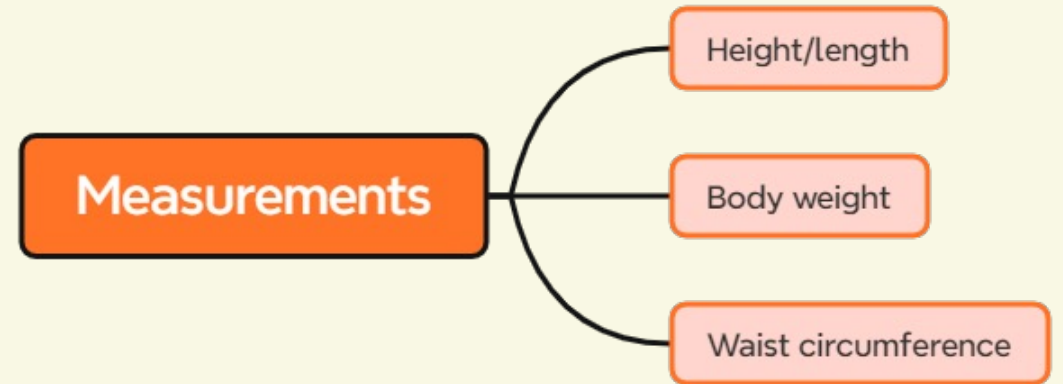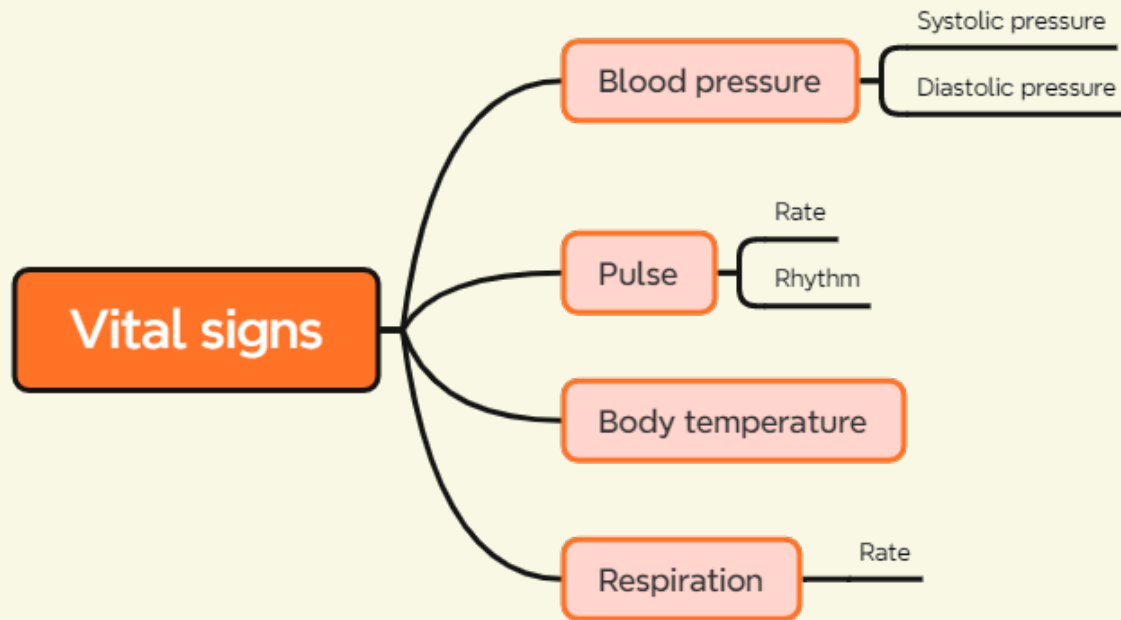
Key biomarkers

- Initial R1 scope to support calculation of cardiovascular risk assessment