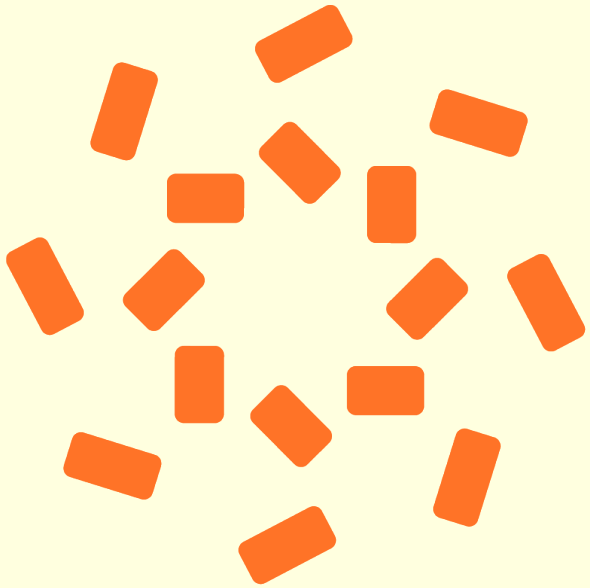

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HL7® FHIR®

Day 2, September 12, 2024

Clinical Design Group


AUCDI RELEASE
Sparked
Sparked
Sparked

Acknowledgement of Country

We acknowledge the Traditional Custodians of the land on which we all gather today, the land of the Jagera and Turrbal people.

We pay our respect to elders past, present, and emerging and extend our respect to all Aboriginal and Torres Strait Islander people. We acknowledge the First Peoples as the first scientists, educators and healers.

Agenda – Day 2

Time	Topic	Facilitator / Speaker
8.30am	Registration	
	eRequesting in Action	
9.00am	eRequesting in Action Introduction and Recap	Michael Hosking
9.15am	eRequesting in Action Requester Perspectives Provider Perspectives Intro to RCPA and RANZCR catalogues Industry perspectives DoHAC perspective	Rob Hosking Ken Sikaris Carmen Wong David Willock Jess White Angus Millar Jeremy Sullivan
10.30am	**Morning Tea**	
11.00am	Workshop 4: eRequesting terminology in Action Identifying opportunities for standardisation of national catalogues	Liam Barnes & Michael Hosking
12.15pm	AUeReqDI Release 1 update	Kylynn Loi
12.30pm	**Lunch**	
	Chronic Disease Management	
1.30pm	Chronic Disease Management Introduction	DoHAC
1.40pm	Chronic Disease Management Perspectives	Jackie O'Connor Steven Kaye Nyree Taylor Tim Blake
2.10pm	Workshop 5: Chronic Disease Management Use Cases – Exploring workflows and scoping	Kylynn Loi & Kate Ebrill
3.00pm	**Afternoon Tea**	
3.30pm	Workshop 5: Chronic Disease Management Continued - Data Group development	Kylynn Loi, Heather Leslie, & Kate Ebrill
4.15pm	Closing remarks and next steps	Kate Ebrill

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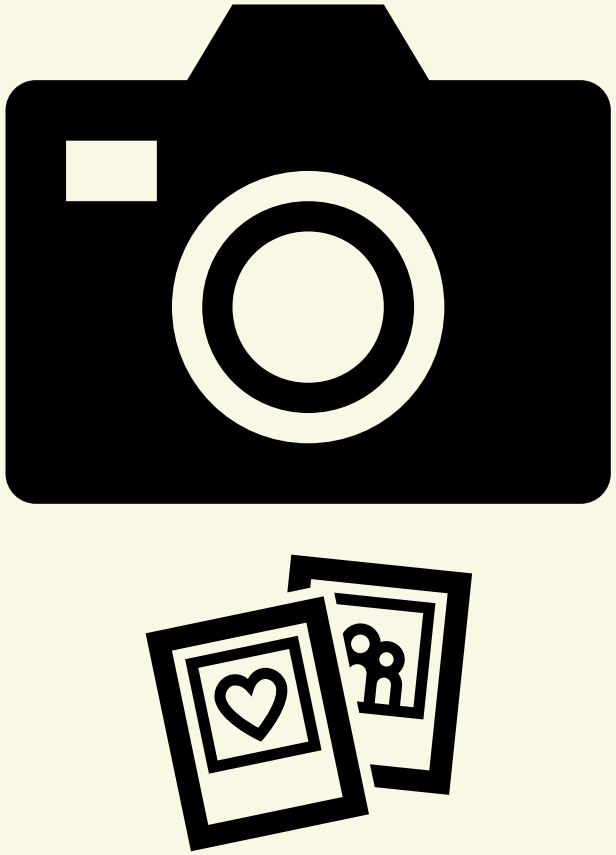
Photos/Video

Please be advised that photographs and video will be taken at the event for use on our website and in other written and online publications.

By entering this event, you consent to the photography and video and using your image and likeness.

If you do not wish to be photographed or videoed, please inform the Sparked team.



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HL7 FHIR

eRequesting in Action

Detailed Agenda – Day 2 AM – eRequesting

Time	Topic	Facilitator / Speaker
8.30am	Registration	
eRequesting in Action		
9.00am	**eRequesting in Action** Introduction and Recap	Michael Hosking
9.15am	**eRequesting in Action** Requester Perspectives Provider Perspectives Intro to RCPA and RANZCR catalogues Industry perspectives DoHAC perspective	Rob Hosking Ken Sikaris Carmen Wong David Willock Jess White Angus Millar Jeremy Sullivan
10.30am	Morning Tea	
11.00am	Demo & Workshop 4: **eRequesting terminology in Action** Identifying opportunities for standardisation of national catalogues	Liam Barnes Michael Hosking

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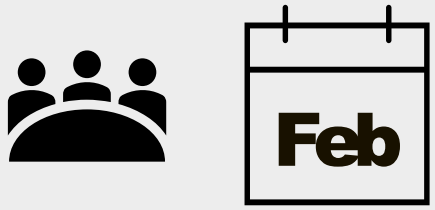
Objectives

Objectives

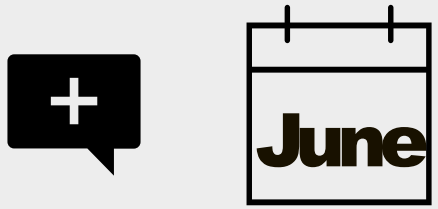
- Revisit our progress on eRequesting
- Discuss the benefits and opportunities of nationally standardised terminology catalogues
- Show how national terminology catalogues can work
- Identify considerations for nationally standardised terminology catalogues

Revisit

Where we've come from

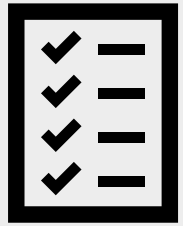


Identified priorities and workflow scope



AUeReqDI R1 comments under review

AUeReqDI R1 to be published



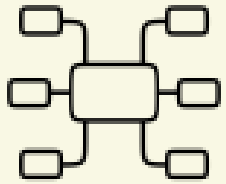
eRequesting Terminology Catalogues under development

eRequesting FHIR Terminology Valuesets under development

What are AU eReq IG and Australian eRequesting Data for Interoperability (AUeReqDI)?

CDG is here

AU eReq DI



Specifies *"WHAT"* **clinical information** (and corresponding **data elements and terms**) should be included for data entry, data use and sharing information supporting **eRequesting**

TDG is here

AU eReq IG

Specifies *"HOW"* the core set of data (above) and information should be **structured, accessed** and **shared** between systems for the **eRequesting** use case

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*noted as clinically relevant but not clinically defined

AUeReqDI R1 Draft for Community scope

Builds upon AUCDI and AU Core – (Patient, Problem/diagnosis (condition), etc.)

AUeReqDI R1 scope

Service request (generic)
- Service name
- Clinical indication
- Clinical context
- Urgency
- Service due
- Comment
- Distribution list*
- Urgent contact*
- Billing guidance*

Implanted device summary*
- Device name
- Status
- Overall comment
- Last updated

Service request (Pathology test request)
- Test name ("Service name")
- Clinical indication
- Clinical context
- Urgency
- Service due
- Comment
- Fasting status
- Distribution list*
- Urgent contact*
- Billing guidance*

Service request (Medical imaging request)
- Test name ("Service name")
- Clinical indication
- Clinical context
- Urgency
- Service due
- Timing
- Comment
- Target body site/laterality
- Modality
- Contrast use
- Distribution list*
- Urgent contact*
- Billing guidance*

CDG is here

Incorporated from AUCDI
- Problem/ Diagnosis
- Adverse reaction risk
- Sex and gender

TDG is here

Proposed IG scope

Service request (generic)
- Requester order identifier
- Billing
- Requester
- Receiver order identifier
- Receiver
- Distribution list

Service request (Pathology test request)
- Requester order identifier
- Billing
- Requester
- Receiver order identifier
- Receiver
- Distribution list
- Specimen collection
  - Collector
  - Collection date/time
  - Identifier/label
  - Body site/laterality
- Self determination
- Rule 3 exemption
- S4B(3) exemption
- Result recipient
- Urgent result contact

Service request (Medical imagin request)
- Requester order identifier
- Billing
- Requester
- Receiver order identifier
- Receiver
- Distribution list
- Result recipient
- Urgent result contact

Identified for AUCDI Backlog
- Current pregnancy status
- Estimated Date of Delivery
- Last menstrual period
- Menstruation summary

Sparked HL7 FHIR

*noted as clinically relevant but not clinically defined

AUeReqDI R1 Draft for Community scope

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TDG is here

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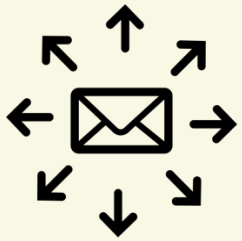
Service request (Medical imaging request)
- Requester order identifier
- Billing
- Requester
- Receiver order identifier
- Receiver
- Distribution list
- Result recipient
- Urgent result contact

TDG is here

Sparked HL7 FHIR

eRequest workflows in scope for R1 Community Consensus from February



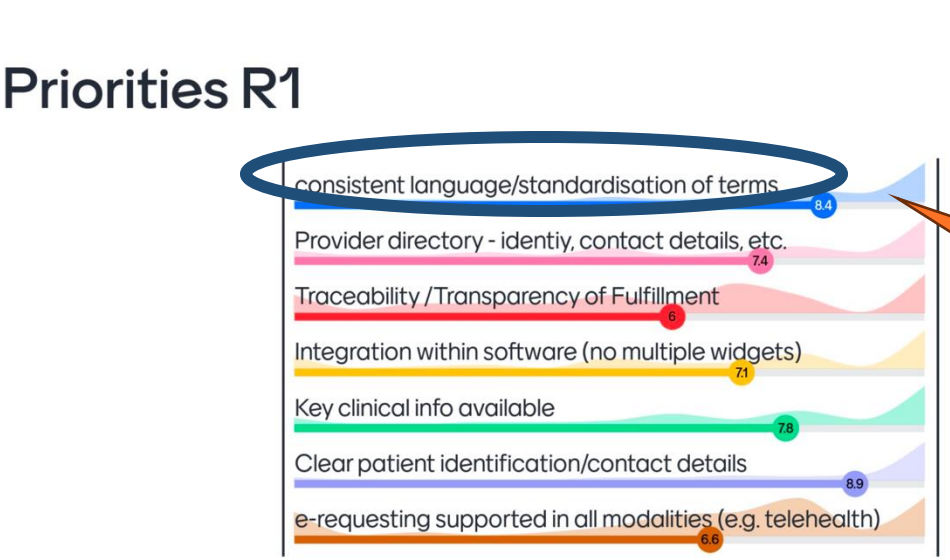
1. Request generated, and **Consumer can choose** a suitable provider

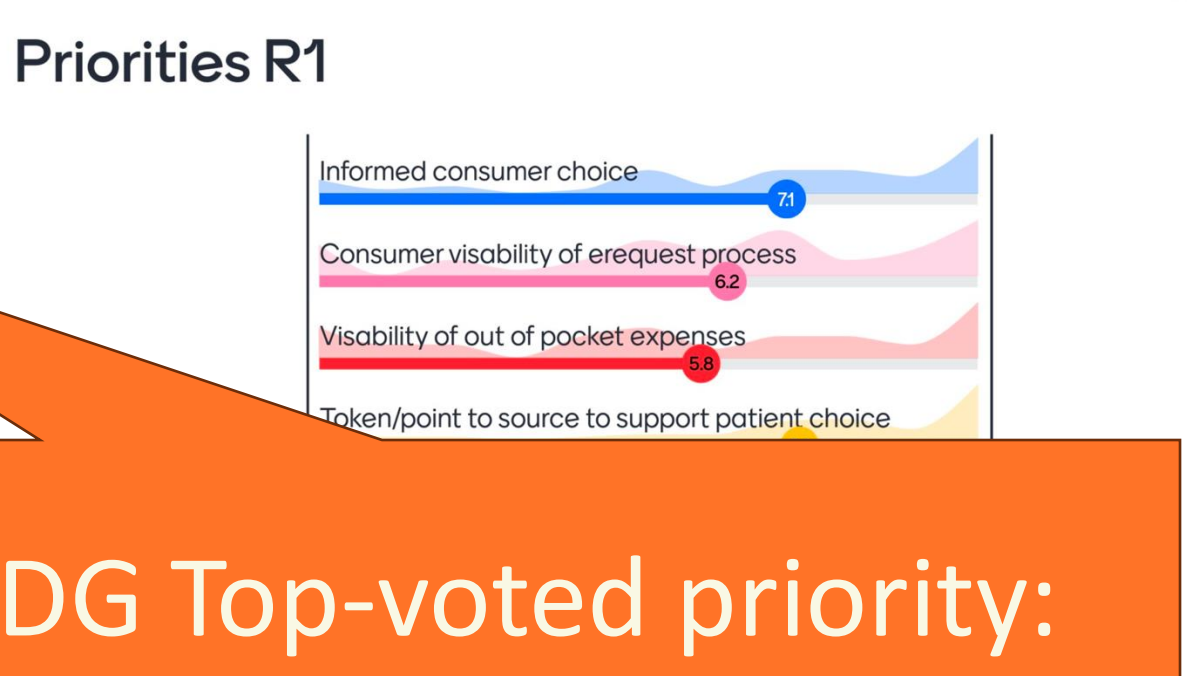
2. Healthcare provider discusses and **agrees with Consumer the recommended provider** with a Request Generated to that provider with the consumer following the recommendation

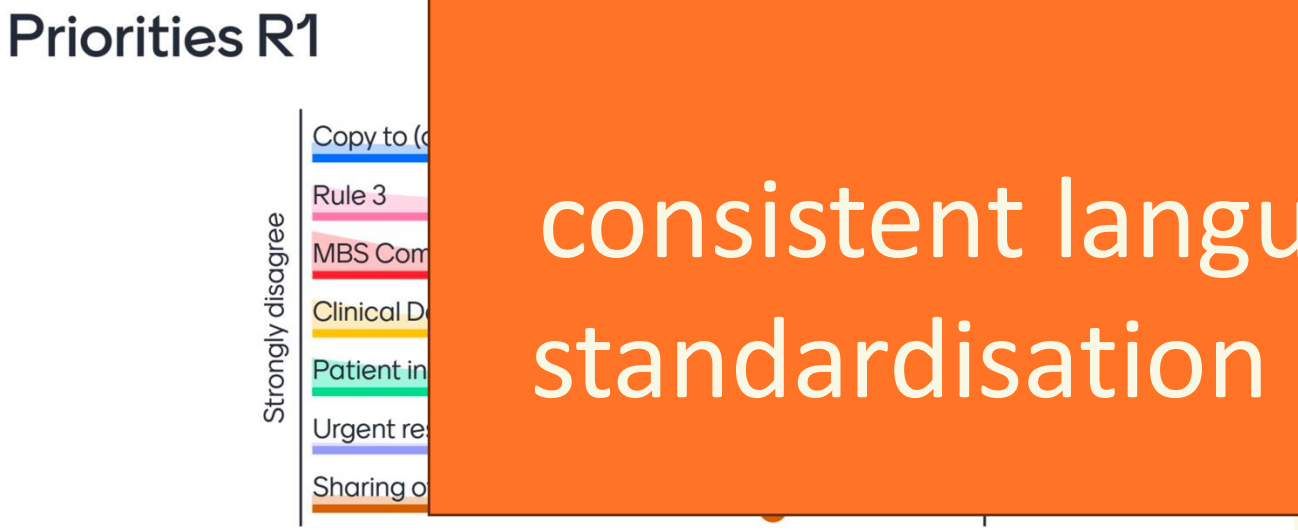
3. Healthcare Provider discusses and **agrees with Consumer** a recommended provider, request generated and later the **consumer chooses an alternative to the recommended provider**

Results from activities held at the 13 Feb 2024 (CDG) workshop

Mentimeter





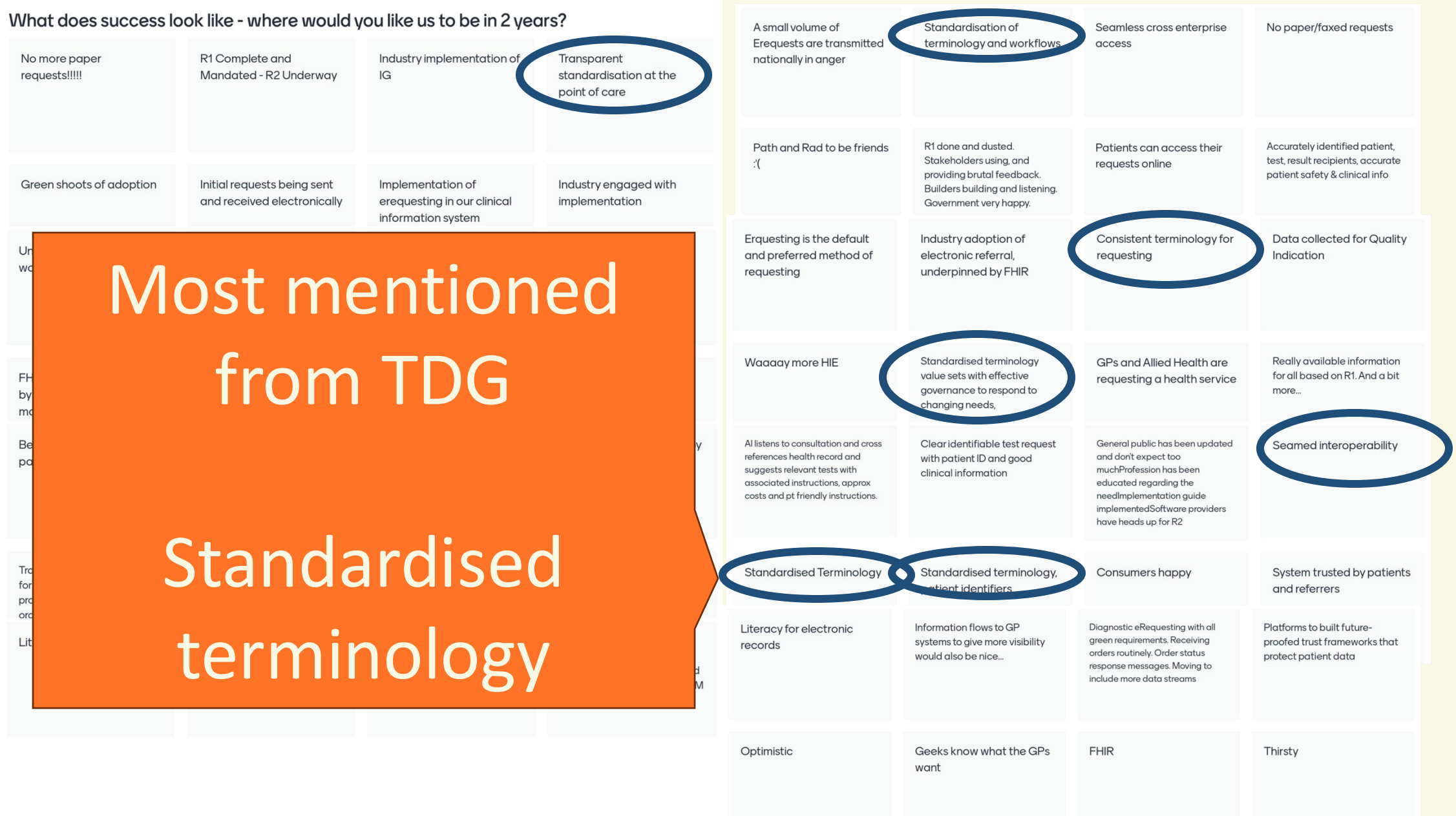


CDG Top-voted priority:

consistent language and standardisation of terms

Sparked HL7 FHIR

Results from activities held at the 14 Feb 2024 (TDG) workshop



Most mentioned from TDG

Standardised terminology

Requester perspective

Rob Hosking
RACGP


WHEN YOU SEE
MULTIPLE DOCTORS

Provider perspective

Ken Sikaris

Dorevitch

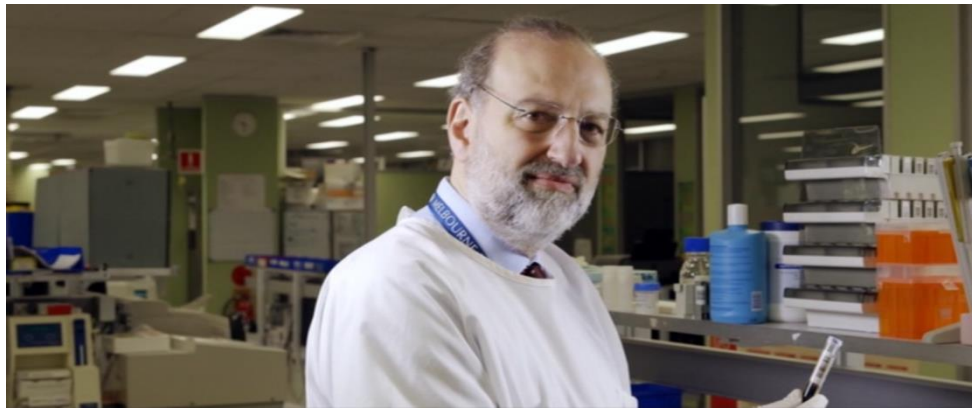
Pathology Requesting

A/Prof Ken Sikaris

BSc, MBBS, FRCPA, FAACB, FFSc, GAICD

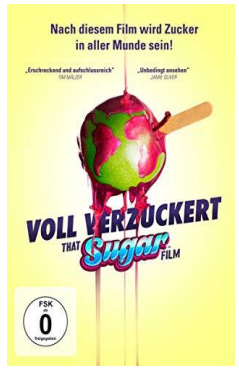
Sparked Community Co-Design Workshop
Brisbane
12th September 2024

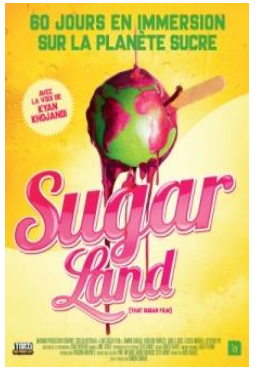

"A DEFINITE MUST-SEE!"
JAMIE OLIVER
"BINGE ON THAT SUGAR FILM AND TRANSFORM YOUR LIFE!"
MORGAN SPURLOCK, DIRECTOR OF SUPER SIZE ME
THAT
Sugar
FILM
THIS WILL CHANGE THE WAY
YOU THINK ABOUT 'HEALTHY' FOOD
thatsugarfilm.com
#thatsugarfilm



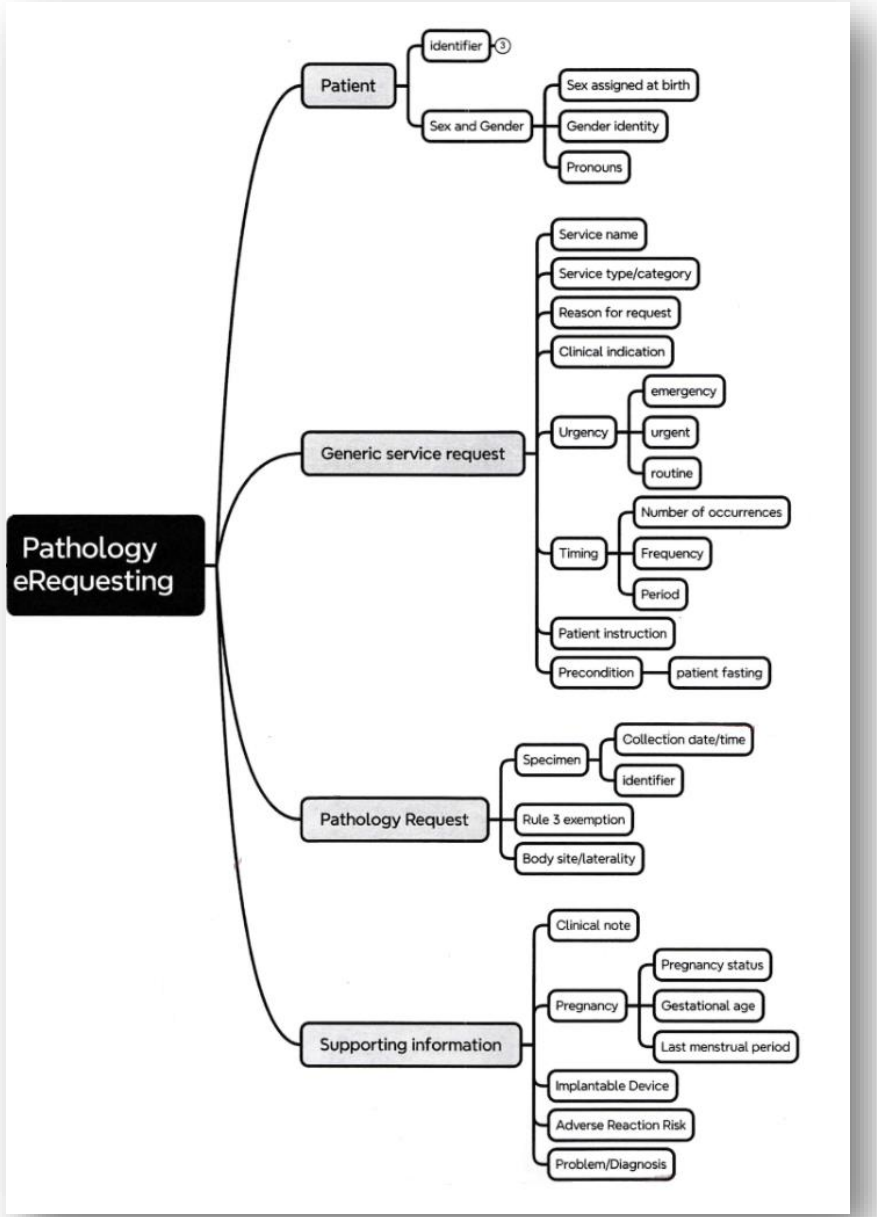

PROFESSOR
BLOOD


THAT
SUGAR
FILM


Nach diesem Film wird Zucker
in aller Munde sein!
VOLL VERZUCKERT
THAT Sugar FILM


60 JOURS EN IMMERSION
SUR LA PLANÈTE SUCRE
Sugar
Land


DAMON GAMEAU
DANNATO
Zucchero!
IL LIBRO
CHE RIVOLUZIONERÀ
LA VOSTRA IDEA
DI CIBO SANO


Pathology eRequesting
Patient
identifier
3
Sex and Gender
Sex assigned at birth
Gender identity
Pronouns
Generic service request
Service name
Service type/category
Reason for request
Clinical indication
Urgency
emergency
urgent
routine
Timing
Number of occurrences
Frequency
Period
Patient instruction
Precondition
patient fasting
Pathology Request
Specimen
Collection date/time
identifier
Rule 3 exemption
Body site/laterality
Supporting information
Clinical note
Pregnancy
Pregnancy status
Gestational age
Last menstrual period
Implantable Device
Adverse Reaction Risk
Problem/Diagnosis

Graham Grieve (MAACB)

AACB Examination Prize	
Mr G Grieve	1992

Examinations

The following people were admitted as Fellows of the Association:

Andrew Wootton
Peter Vervaart

The following people were admitted as Members of the Association:

Richard Banter
Christine Chin
Michael Freemantle
Grahame Grieve
Graham Jones
David Kanowski
Susan Kilbride
Ivan Peluso
Mary Anne Townsend
Samuel Vasikaran

David Kanowski and Mary Anne Townsend were commended for attaining a high standard in the examination and Grahame Grieve was awarded the AACB Examination Prize.

Herbert K, Sikaris KA, **Grieve G**, O'Neal D, Lee P, Hale G, Best JD,

Lipid risk factor profiles in Women with Coronary Artery Disease; Influence of Diabetes. Proceedings of the 1995 Atherosclerosis Society Annual Meeting, 1995

Schneider HG, **Grieve G,** Desmond P, Sikaris KA,

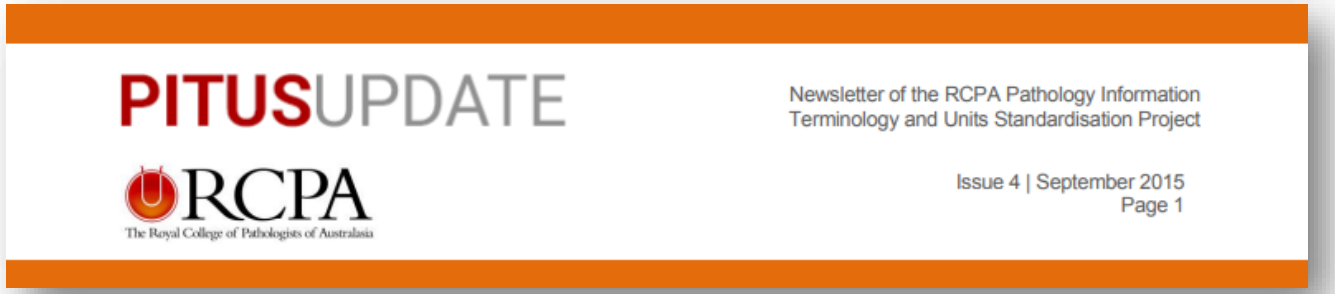
Amylase Versus Lipase in the diagnosis of pancreatic disease. Proceedings of the XVI IFCC Congress, London, June 1996.

Pathology Units and Terminology Standardisation

PUTS 2012

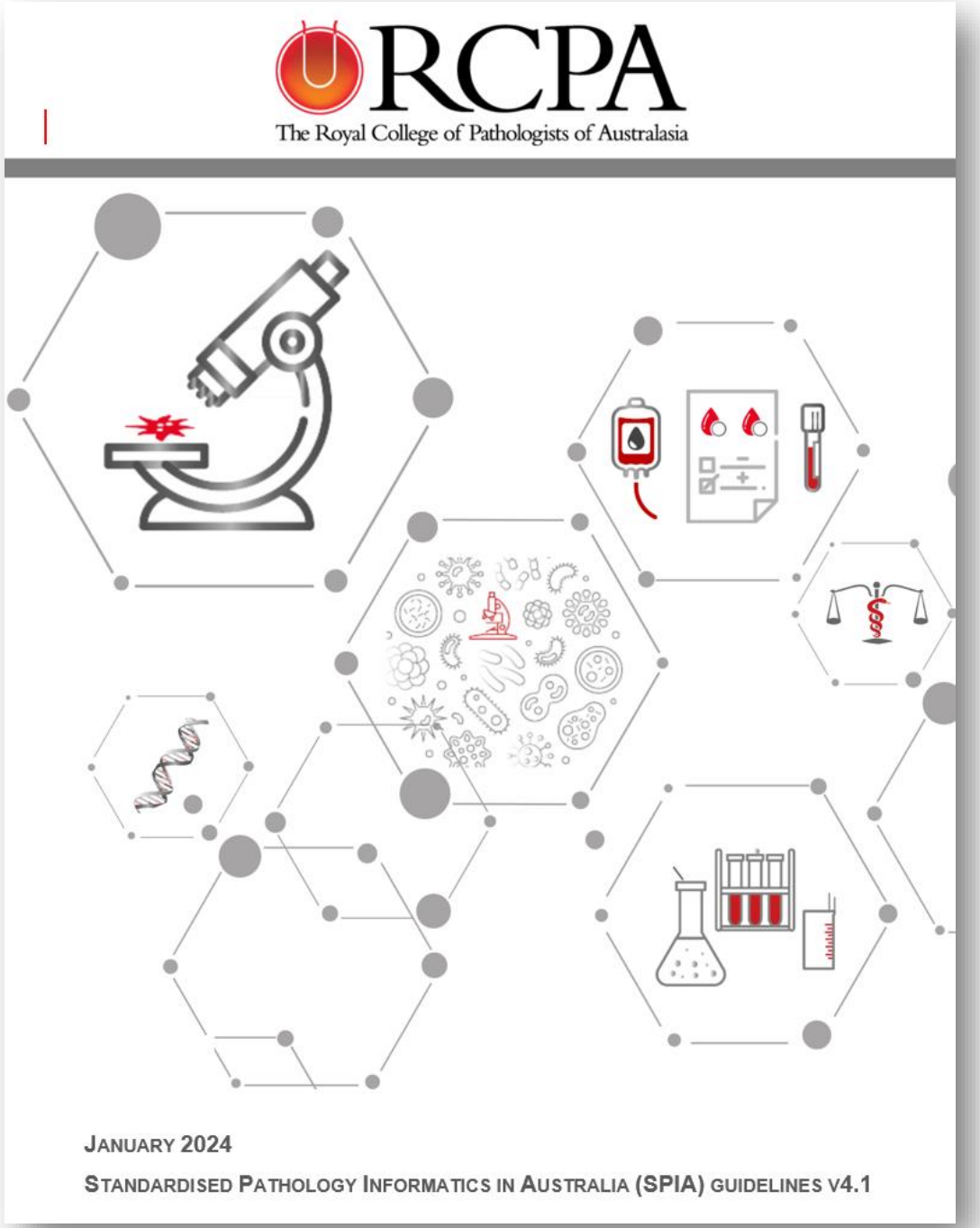
Pathology Information Terminology and Units Standardisation

PITUS 2014



PITUS 2016

PITUS 2018-20



RCPA

SPIA

Standardised Pathology Informatics in Australia

V4.1

9 Safe pathology requesting

S9.04 Pathology requests should be computer-generated.

S9.09 Computer systems used for requesting pathology or decision support should allow for the capture of pertinent clinical information.

S9.11 Computer systems used for requesting pathology must support the use of standardised terminology for pathology tests.

S9.13 The clinician must have access to appropriate knowledge systems to assist with ordering relevant pathology tests.

S9.14 Electronic requesting systems should have electronic decision support.

Ann Intern Med. 2006;145:488-496.

Missed and Delayed Diagnoses in the Ambulatory Setting: A Study of Closed Malpractice Claims

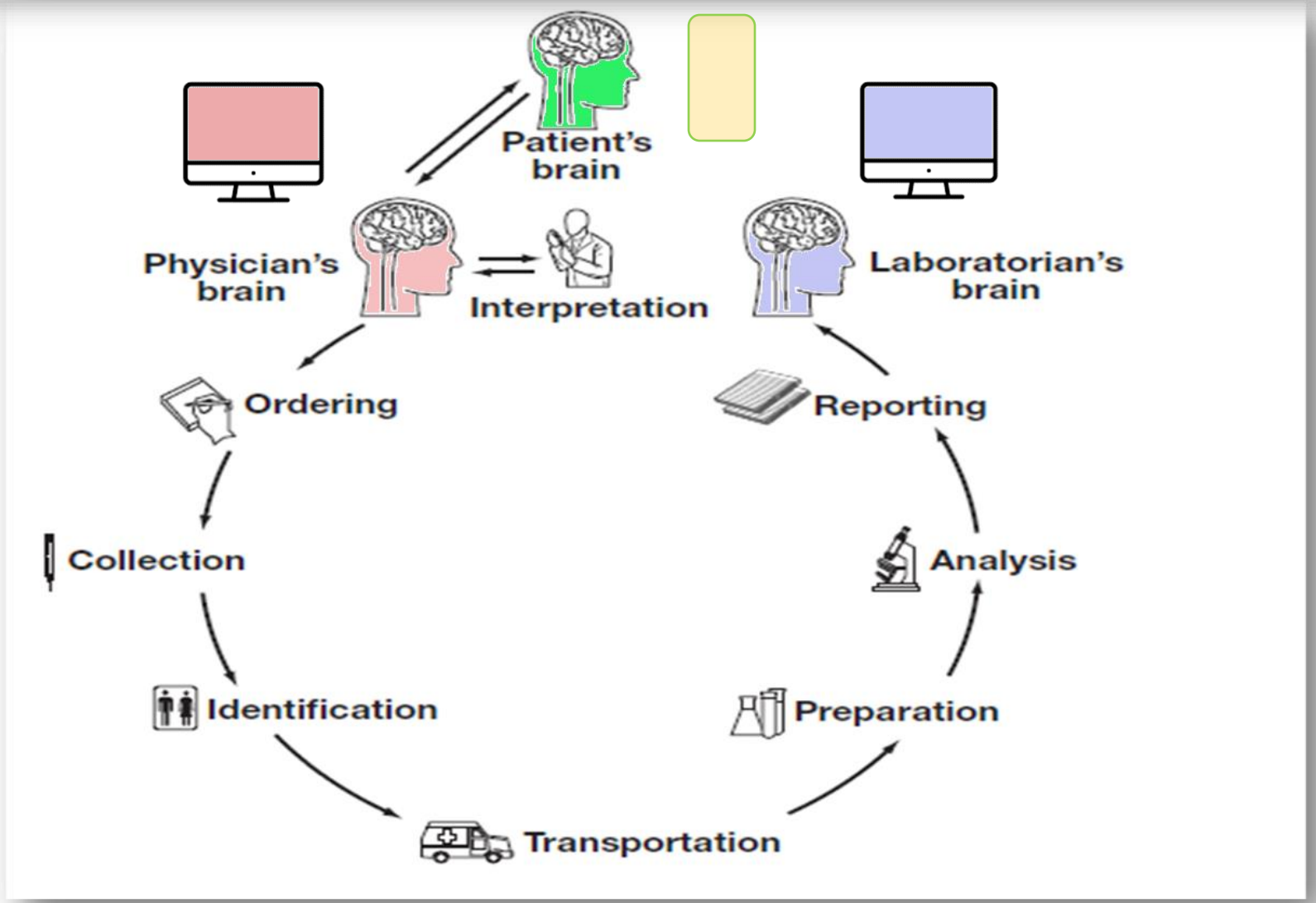
Tejal K. Gandhi, MD, MPH; Allen Kachalia, MD, JD; Eric J. Thomas, MD, MPH; Ann Louise Puopolo, BSN, RN; Catherine Yoon, MS; Troyen A. Brennan, MD, JD; and David M. Studdert, LLB, ScD

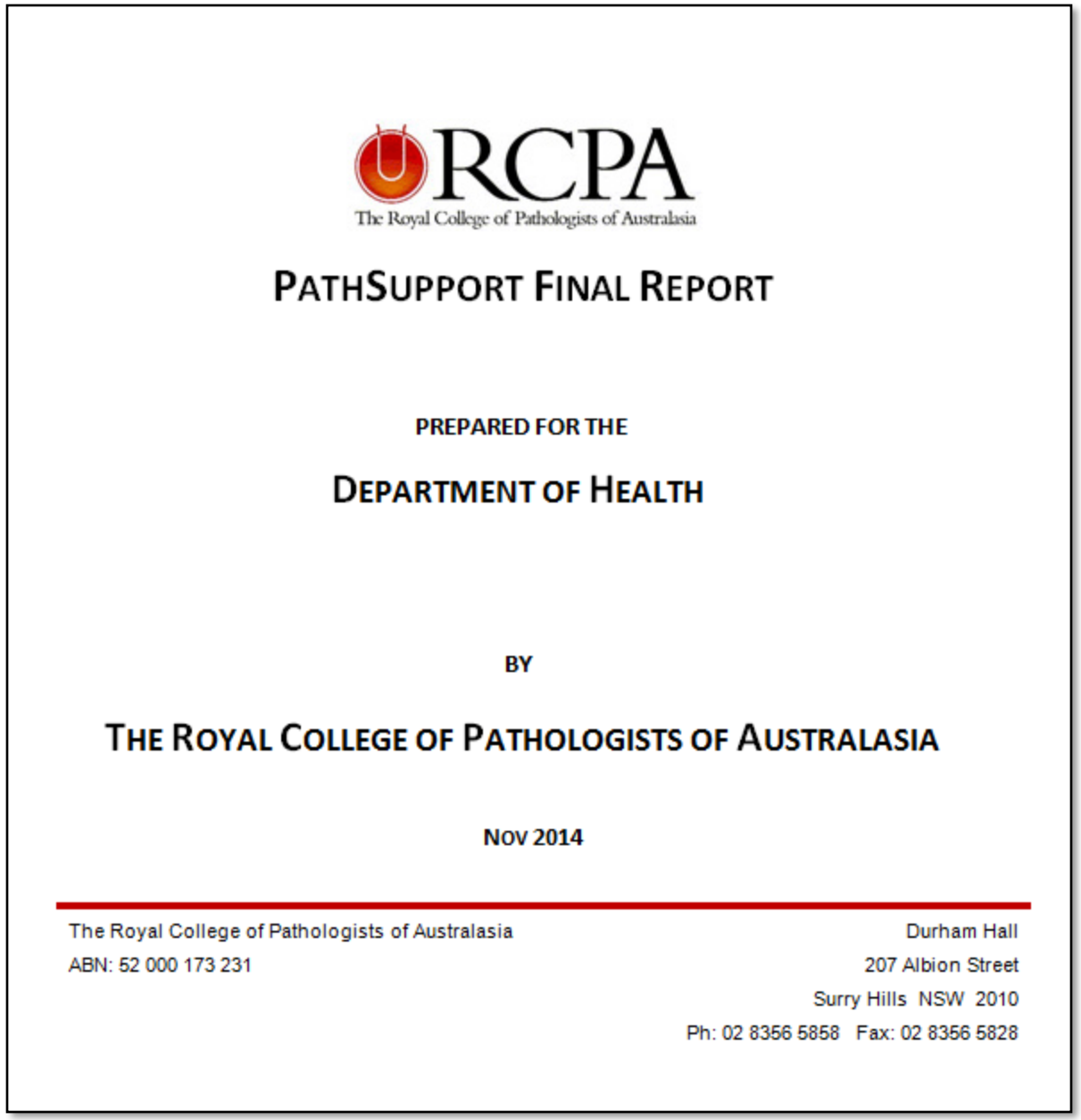
- Diagnostics Errors: 181/370 (59%) of malpractice claims
  - 59% serious harm, 30% death
  - Causes
    - **55% failure to order diagnostic test**
    - 45% no follow up plan
    - 37% no history / examination
    - **37% incorrect interpretation diagnostic test**

Am J Clin Pathol 2011;136:829-833

The Brain-to-Brain Loop Concept for Laboratory Testing 40 Years After Its Introduction

Mario Plebani, MD,[1] Michael Laposata, MD, PhD,[2] and George D. Lundberg, MD[3]




RCPA
The Royal College of Pathologists of Australasia

PATHSUPPORT FINAL REPORT

PREPARED FOR THE

DEPARTMENT OF HEALTH

BY

THE ROYAL COLLEGE OF PATHOLOGISTS OF AUSTRALASIA

NOV 2014

The Royal College of Pathologists of Australasia
ABN: 52 000 173 231

Durham Hall
207 Albion Street
Surry Hills NSW 2010
Ph: 02 8356 5858 Fax: 02 8356 5828

- *Aim*

- *to seek input on the possible use of desktop software to help improve the quality of pathology ordering by General Practitioners*

- ***Monash University***
- ***UNSW / AIHI***
- ***University of Sydney / FMRC***
- ***National Prescribing Service***
- ***Pathology Sector***
- ***Desktop Software Vendors***
- ***GP Workshops***

RCPA PathSupport;

Consensus of problems identified

Clinician

1. Difficulty in providing the best care due to lack of clinical context
2. Difficulty in requesting "recommended" tests due to lack of easily accessed guidance
3. Difficulty in avoiding the ordering of tests of "no value" for a context.
4. The generation of unintended bills due to lack of knowledge of Medicare schedule
5. Difficulty in ordering "additional tests" due to lack of knowledge
6. Specimen collection issues due to lack of patient information sheets
7. Time wasted and reduction in quality of care due to data entry errors (eRequesting)
8. Difficulty in providing the best pathology consulting due to a lack of *further* clinical information associated with the test e.g. current medications, current problems

Patient

Pathology

Design Principles

1. Manually override suggest tests
2. No negative impact on workflow

The need for clinical information in e-Requests

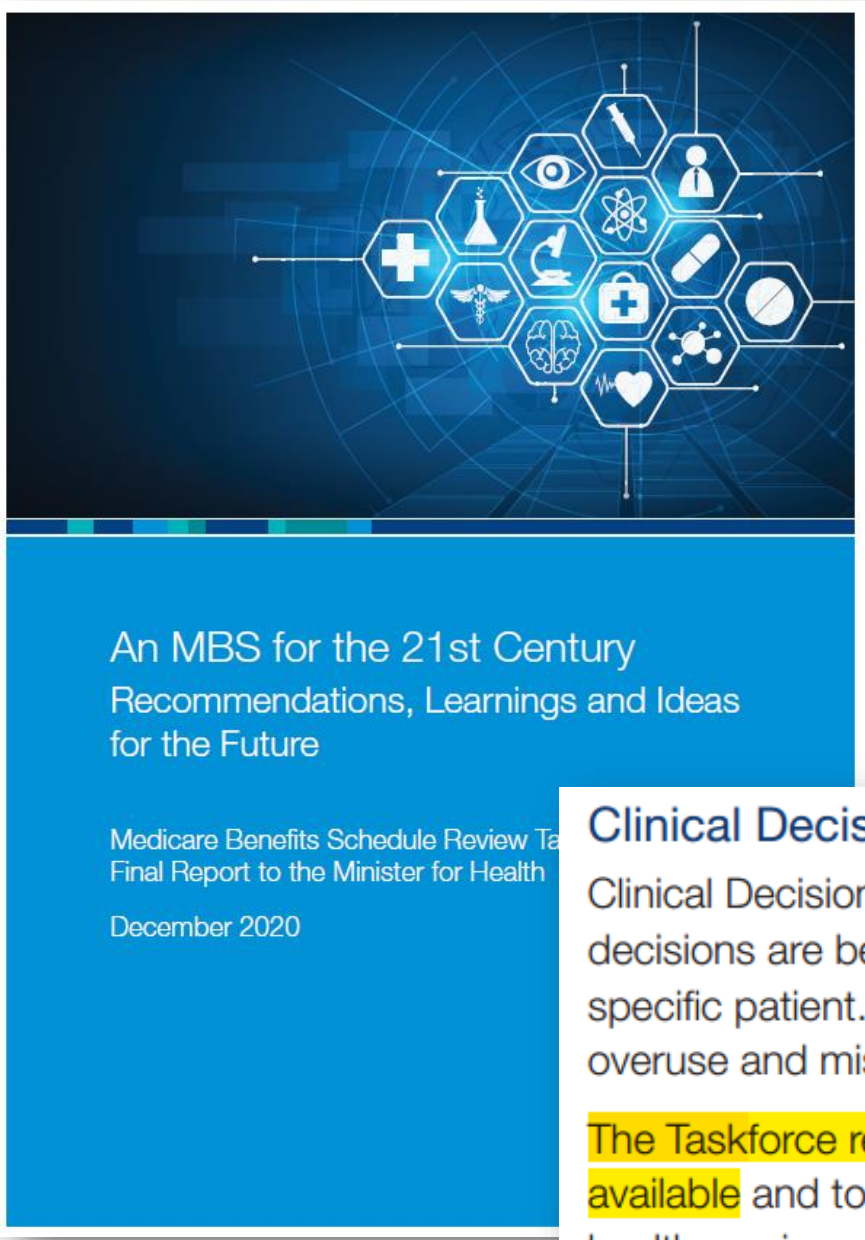
1. Reimbursement Requirement

2. To perform the correct tests for that clinical context

3. To interpret the pathology results in that clinical context

including the identification and urgent communication of life threatening results

MBS Review; Final Report

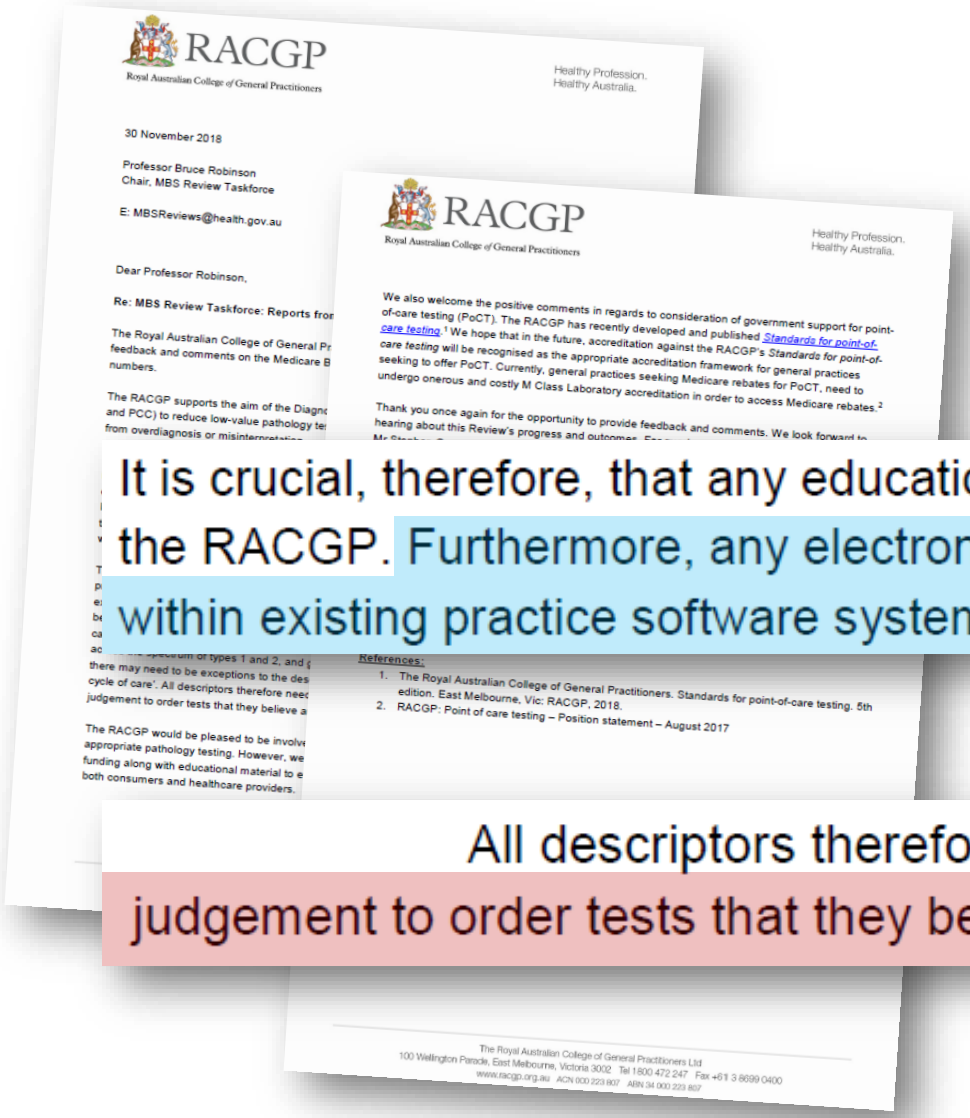


Clinical Decision Support

Clinical Decision Support (CDS) can be defined as 'the provision of advice at the point of care (when decisions are being made by the medical professional) that is tailored to the clinical context of the specific patient.' CDS can enhance high value advanced imaging requests, reduce inappropriate overuse and misuse, and provide a source of clinical knowledge for requesting clinicians.

The Taskforce recommends a focused effort to support the use of CDS tools that are currently available and to facilitate the development and expansion of CDS tools to enable appropriate use of health services.

RACGP Response


RACGP
Royal Australian College of General Practitioners
Healthy Profession. Healthy Australia.

30 November 2018

Professor Bruce Robinson
Chair, MBS Review Taskforce

E: MBSReviews@health.gov.au

Dear Professor Robinson,

Re: MBS Review Taskforce: Reports fro

The Royal Australian College of General Pr
feedback and comments on the Medicare B
numbers.

The RACGP supports the aim of the Diagno
and PCC) to reduce low-value pathology te
from overdiagnosis or misinterpretation

there may need to be exceptions to the des
cycle of care'. All descriptors therefore nee
judgement to order tests that they believe a

The RACGP would be pleased to be involve
appropriate pathology testing. However, we
funding along with educational material to e
both consumers and healthcare providers.

RACGP
Royal Australian College of General Practitioners
Healthy Profession. Healthy Australia.

We also welcome the positive comments in regards to consideration of government support for point-of-care testing (PoCT). The RACGP has recently developed and published *Standards for point-of-care testing*.[1] We hope that in the future, accreditation against the RACGP's *Standards for point-of-care testing* will be recognised as the appropriate accreditation framework for general practices seeking to offer PoCT. Currently, general practices seeking Medicare rebates for PoCT, need to undergo onerous and costly M Class Laboratory accreditation in order to access Medicare rebates.[2]

Thank you once again for the opportunity to provide feedback and comments. We look forward to

References:

1. The Royal Australian College of General Practitioners. Standards for point-of-care testing. 5th edition. East Melbourne, Vic: RACGP, 2018.
2. RACGP: Point of care testing – Position statement – August 2017

The Royal Australian College of General Practitioners Ltd
100 Wellington Parade, East Melbourne, Victoria 3002 Tel 1800 472 247 Fax +61 3 8699 0400
www.racgp.org.au ACN 000 223 807 ABN 34 000 223 807

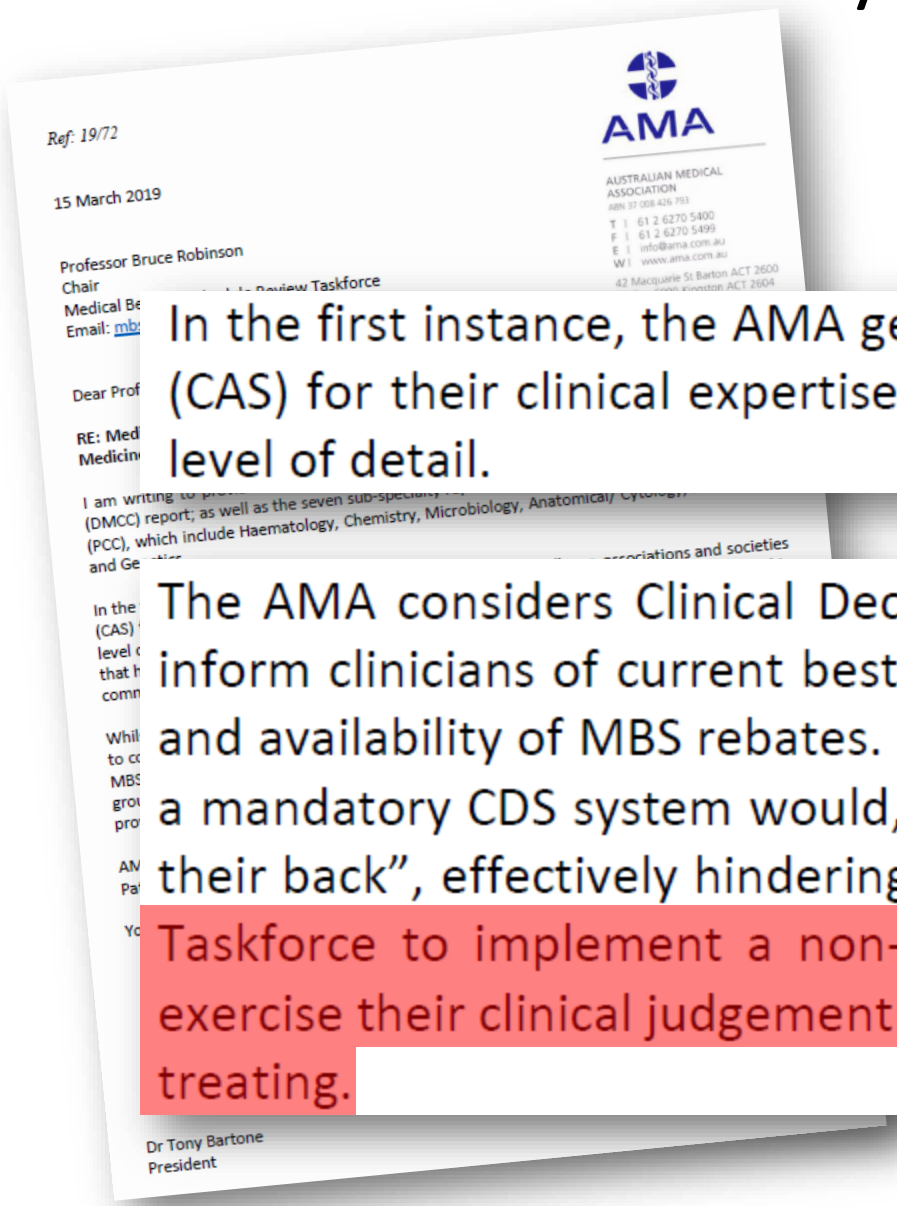
Integration

It is crucial, therefore, that any education and decision support is developed in close consultation with the RACGP. Furthermore, any electronic clinical decision support would need to be implemented within existing practice software systems for this mechanism to be effective.

All descriptors therefore need to be flexible, so clinicians can use their own clinical judgement to order tests that they believe are clinically relevant for the patient.

Clinical autonomy

AMA Response



Ref: 19/72

15 March 2019

AMA

AUSTRALIAN MEDICAL ASSOCIATION

Professor Bruce Robinson
Chair

Dear Prof

RE: Med
Medicin

I am writing to
(DMCC) report; as well as the seven sub-specialty
(PCC), which include Haematology, Chemistry, Microbiology, Anatomical/ Cytology,
and Ge

In the
(CAS)
level
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Whil
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MBS
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pro

AM
Pa

Yo

Dr Tony Bartone
President

In the first instance, the AMA generally refers to the relevant colleges, associations and societies (CAS) for their clinical expertise and advice on the report findings and recommendations at this level of detail.

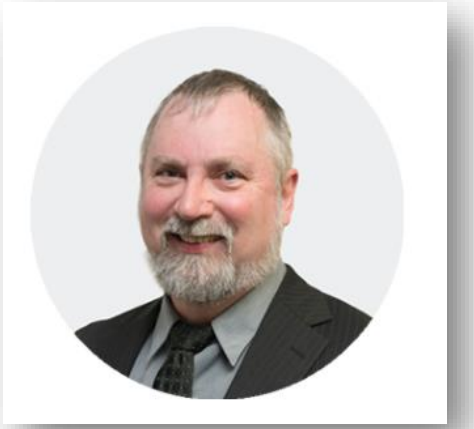
The AMA considers Clinical Decision Support (CDS) systems to be useful tools to educate and inform clinicians of current best practice, at the point of care, for requesting of diagnostic tests and availability of MBS rebates. However, the AMA believes that the DMCC recommendation for a mandatory CDS system would, as an AMA representative conveyed "tie doctors' hands behind their back", effectively hindering their ability to tailor care for patients. The AMA urges the MBS Taskforce to implement a non-mandatory CDS system and/or allow clinicians to continue to exercise their clinical judgement in relation to the particular circumstances of the patient they are treating.

AMA Response;

Integration

Furthermore, if a CDS system is implemented, a key issue will be to ensure the system is integrated into clinical software, and not be a stand-alone system, so that pathologists can communicate results quickly, effectively, and equitably to requesting and treating doctors.

I have been advised that CDS prototypes exists and feedback from members reveal there are several good systems worldwide for radiology including the one developed at Royal Perth Hospital in Western Australia. I am also aware that the RCPA has undertaken extensive work (funded by the Department of Health) in developing CDS prototypes for pathology. It would therefore be logical for the Taskforce to leverage this work, if the initial trial of CDS for radiology items proves acceptable to the medical profession and is effective in ensuring clinically appropriate requesting of diagnostic tests.



Dr Frank Pyefinch

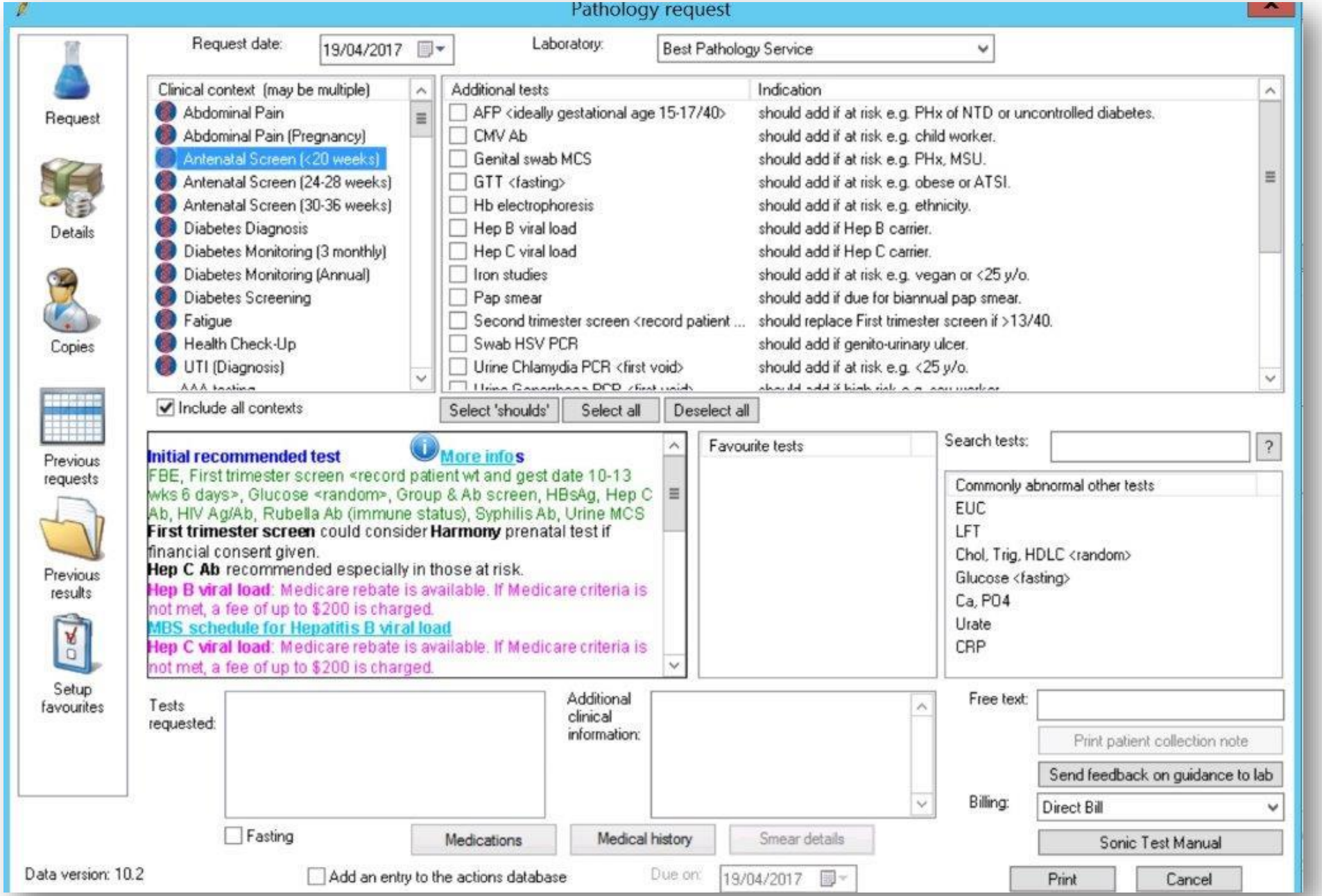
MBBS , Grad Dip IT

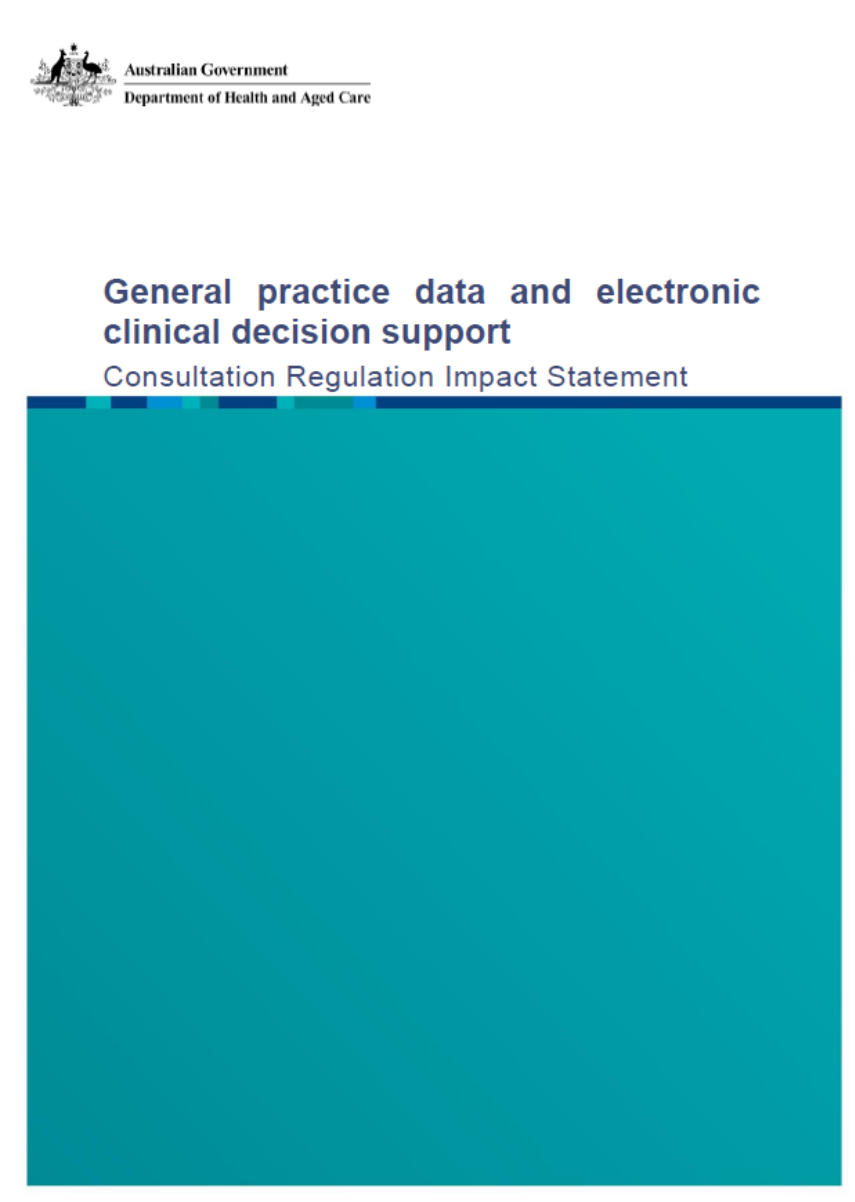
Chief Executive Officer

Lorraine Pyefinch

BHSc (Nursing), MMNT

Executive Director


Pathology request
Request date: 19/04/2017
Laboratory: Best Pathology Service
Request
Details
Copies
Previous requests
Previous results
Setup favourites
Clinical context (may be multiple)
Abdominal Pain
Abdominal Pain (Pregnancy)
Antenatal Screen (<20 weeks)
Antenatal Screen (24-28 weeks)
Antenatal Screen (30-36 weeks)
Diabetes Diagnosis
Diabetes Monitoring (3 monthly)
Diabetes Monitoring (Annual)
Diabetes Screening
Fatigue
Health Check-Up
UTI (Diagnosis)
Additional tests
Indication
AFP <ideally gestational age 15-17/40> should add if at risk e.g. PHx of NTD or uncontrolled diabetes.
CMV Ab should add if at risk e.g. child worker.
Genital swab MCS should add if at risk e.g. PHx, MSU.
GTT <fasting> should add if at risk e.g. obese or ATSI.
Hb electrophoresis should add if at risk e.g. ethnicity.
Hep B viral load should add if Hep B carrier.
Hep C viral load should add if Hep C carrier.
Iron studies should add if at risk e.g. vegan or <25 y/o.
Pap smear should add if due for biannual pap smear.
Second trimester screen <record patient ... should replace First trimester screen if >13/40.
Swab HSV PCR should add if genito-urinary ulcer.
Urine Chlamydia PCR <first void> should add if at risk e.g. <25 y/o.
Include all contexts
Select 'shoulds'
Select all
Deselect all
Initial recommended test
More infos
FBE, First trimester screen <record patient wt and gest date 10-13 wks 6 days>, Glucose <random>, Group & Ab screen, HBsAg, Hep C Ab, HIV Ag/Ab, Rubella Ab (immune status), Syphilis Ab, Urine MCS
First trimester screen could consider Harmony prenatal test if financial consent given.
Hep C Ab recommended especially in those at risk.
Hep B viral load: Medicare rebate is available. If Medicare criteria is not met, a fee of up to $200 is charged.
MBS schedule for Hepatitis B viral load
Hep C viral load: Medicare rebate is available. If Medicare criteria is not met, a fee of up to $200 is charged.
Favourite tests
Search tests:
?
Commonly abnormal other tests
EUC
LFT
Chol, Trig, HDLC <random>
Glucose <fasting>
Ca, PO4
Urate
CRP
Tests requested:
Additional clinical information:
Free text:
Print patient collection note
Send feedback on guidance to lab
Billing:
Direct Bill
Fasting
Medications
Medical history
Smear details
Sonic Test Manual
Data version: 10.2
Add an entry to the actions database
Due on:
19/04/2017
Print
Cancel



4. Problems with eCDS

- Lack of transparency of evidence base for some eCDS recommendations
- Challenges integrating eCDS functionality onto clinical workflow
- Lack of oversight on implementation, integration and use of eCDS
- No central repository for clinical guidelines
- Clinical guidelines not optimised for integration into eCDS

Solved vs Still to solve

- help healthcare providers to deliver more effective and timely health care through informative, evidence-based **clinical decision support systems** and data-driven insights.

SMART®

HL7 FHIR

SNOMED CT
The global language o healthcare

eRequesting and electronic Clinical Decision Support

The Australian Government has invested $5.8 million over two years from 2023-24 for the Department of Health and Aged Care to collaborate with key sector stakeholders to design a national eRequesting capability. This work includes establishing the technical, clinical terminology and exchange standards required to implement a national eRequesting capability for pathology and diagnostic imaging health services, subject to future decisions of government.

This co-design process will establish the ability to implement the first end-to-end digital pathway for patients and their healthcare providers, from an eRequest to diagnostic result that would be shared to My Health Record. This work will establish information and data standards for pathology and diagnostic imaging, enabling electronic Clinical Decision Support (eCDS) tools and systems to support health

Short-term horizon

Partners

CSIRO

Australian Digital Health Agency

Software industry

This work will establish information and data standards for pathology and diagnostic imaging, enabling electronic Clinical Decision Support (eCDS) tools and systems to support health professionals across their scope of practice.

Nationally Standardised Catalogues (Radiology)

Carmen Wong
RANZCR

The Royal Australian and New Zealand College of Radiologists®

The Faculty of Clinical Radiology

Standardised terminology for Radiology

SPARKED CDG WORKSHOP

Carmen Wong

12 September 2024

Toward interoperability

Foundational Interoperability

Secure data exchange without processing.

Structural Interoperability

Data is formatted for easy exchange and understanding.

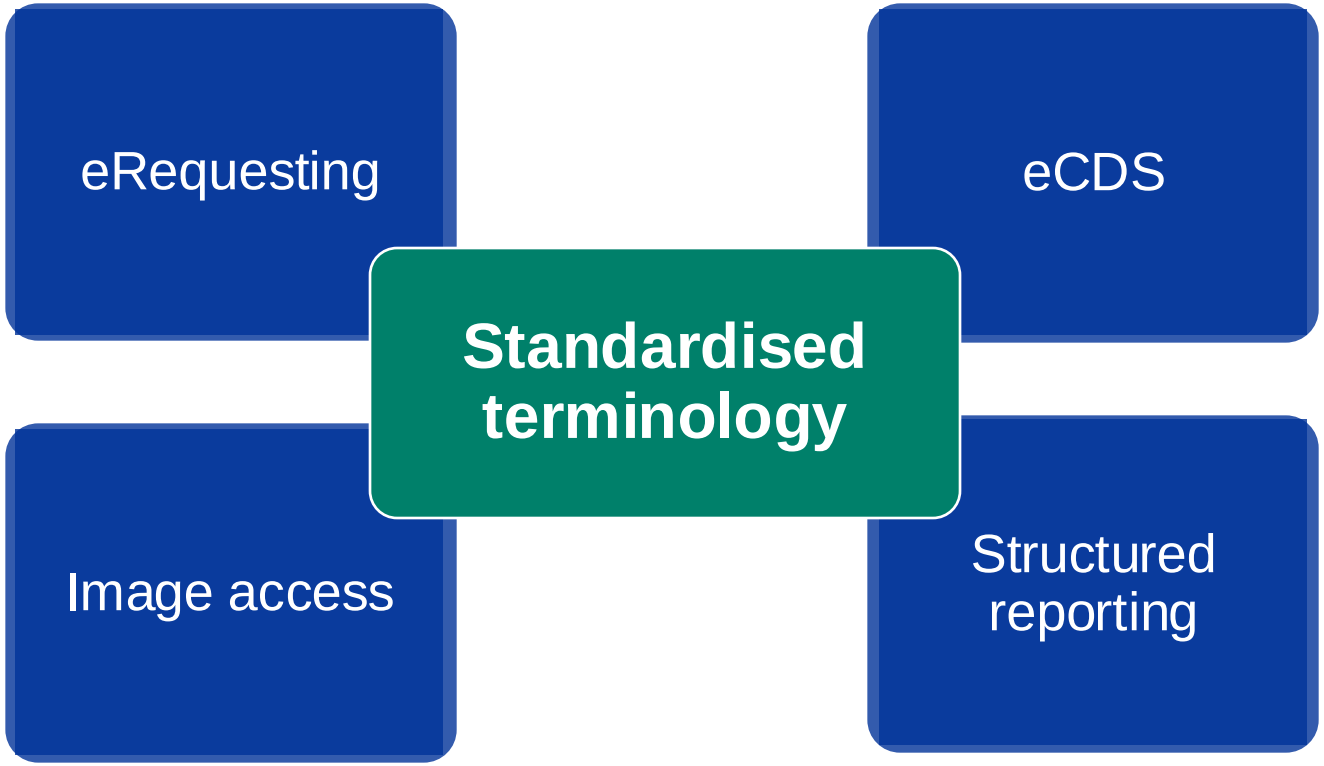
Semantic Interoperability

Standardised codes and terminology enable accurate data exchange.

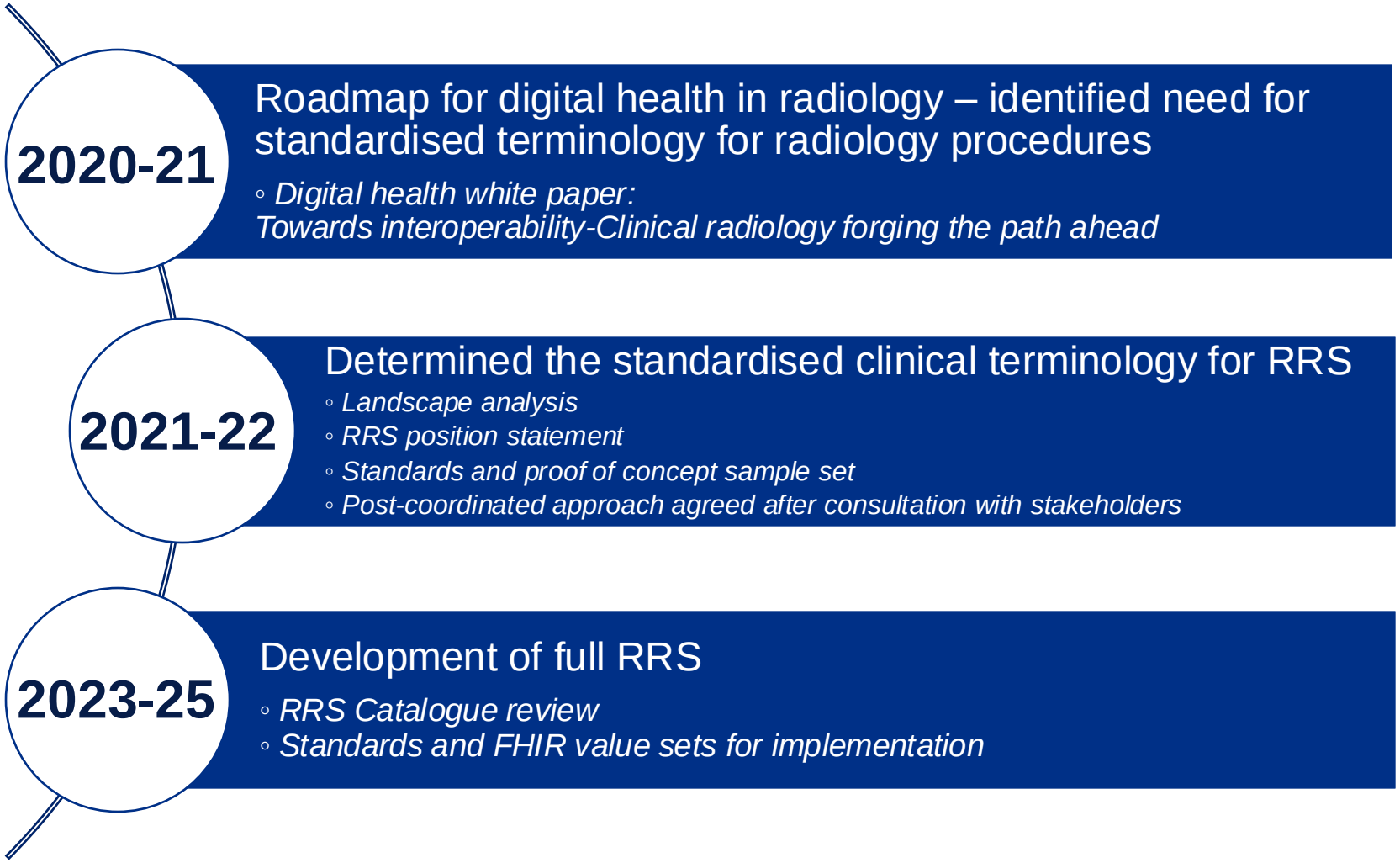
Organisational Interoperability

Governance, policy, and organisational considerations to facilitate seamless and secure data exchange across healthcare entities

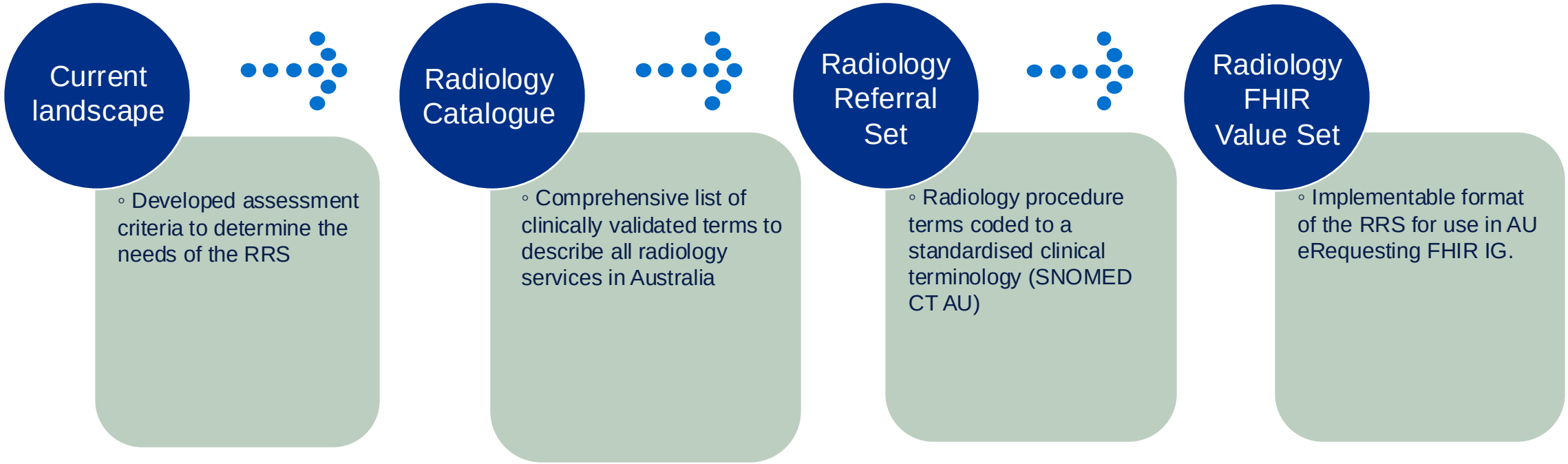
Use cases


eRequesting
eCDS
Standardised terminology
Image access
Structured reporting

Radiology Referral Set



Development approach



Guiding Principles

Term Structure

Common structure based on three fields:

- Modality
- Body site
- Laterality

A fourth field of contrast usage is added when relevant

Clinical Relevance

Terms must refer to clinically relevant procedures and not those that are only theoretically possible.

Granularity

Balance between unambiguous specification of the examination and limiting the number of permitted terms.

Specificity

The term should be the most specific one referring to the whole of the region routinely included in the examination

Additional Editorial Guidance Required

- Nuclear Medicine
- Interventional Radiology & Interventional Neuroradiology
- Hybrid Modalities

Term structure

Modality/ Subspecialty	Body Site	Laterality	Contrast use
• Ultrasound • X-ray • CT • MRI • Nuclear medicine • Interventional radiology • PET	• Applicable body site or region	• Left • Right • Both • Not applicable	• Contrast **can** be used as a part of this procedure • Contrast **is not** used as a part of this procedure

Progress to date

2100+

By modality, subspecialty

Diagnostic imaging complete

1000+ terms

2200+ terms

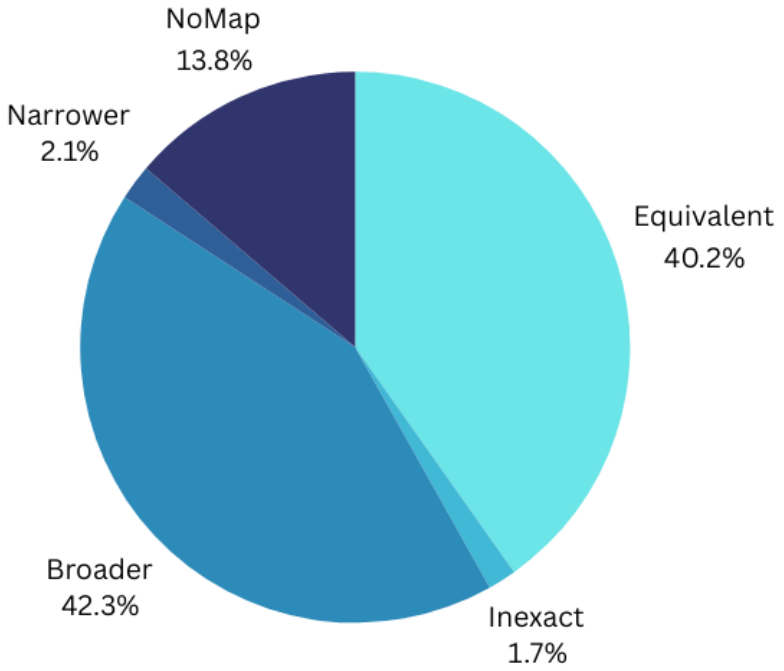
4500 SNOMED-CT expressions*

*Estimated Sept 2024, this figure may change during the clinical review process and gaps are identified or procedures are deprecated

Progress to date

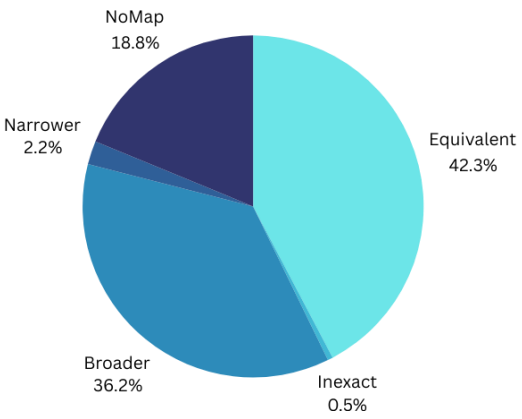
- 2228 unique terms uploaded to SNAP2SNOMED
- 698 directly equivalent mapped terms
- 735 broader terms requiring refinement
- 36 narrower terms requiring refinement.
- 29 inexact terms requiring refinement.
- 239 terms with no representation within SNOMED-CT AU

RRS coverage in SNOMED-CT AU

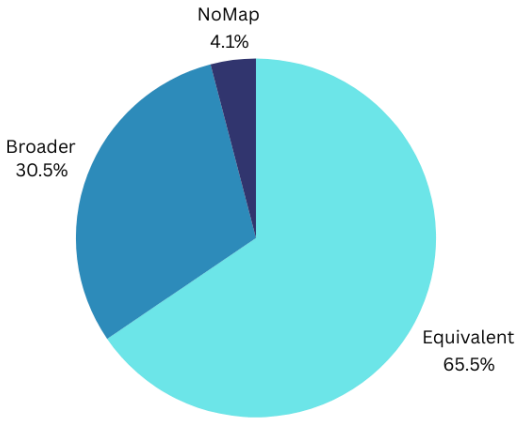


SNOMED CT coverage

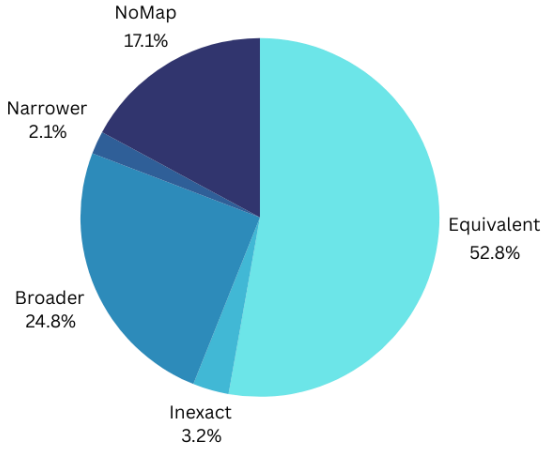
ULTRASOUND



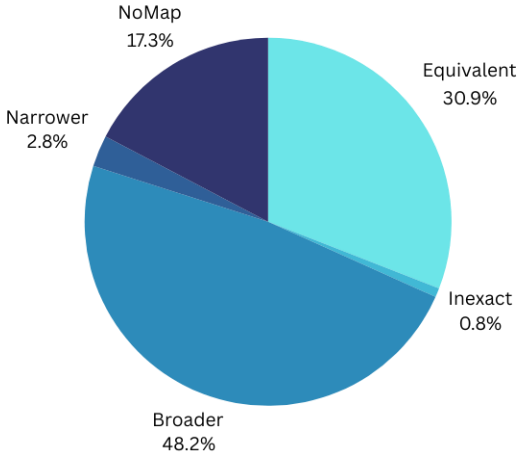
X-RAY



MRI



CT



Progress to date RRV draft candidate v1

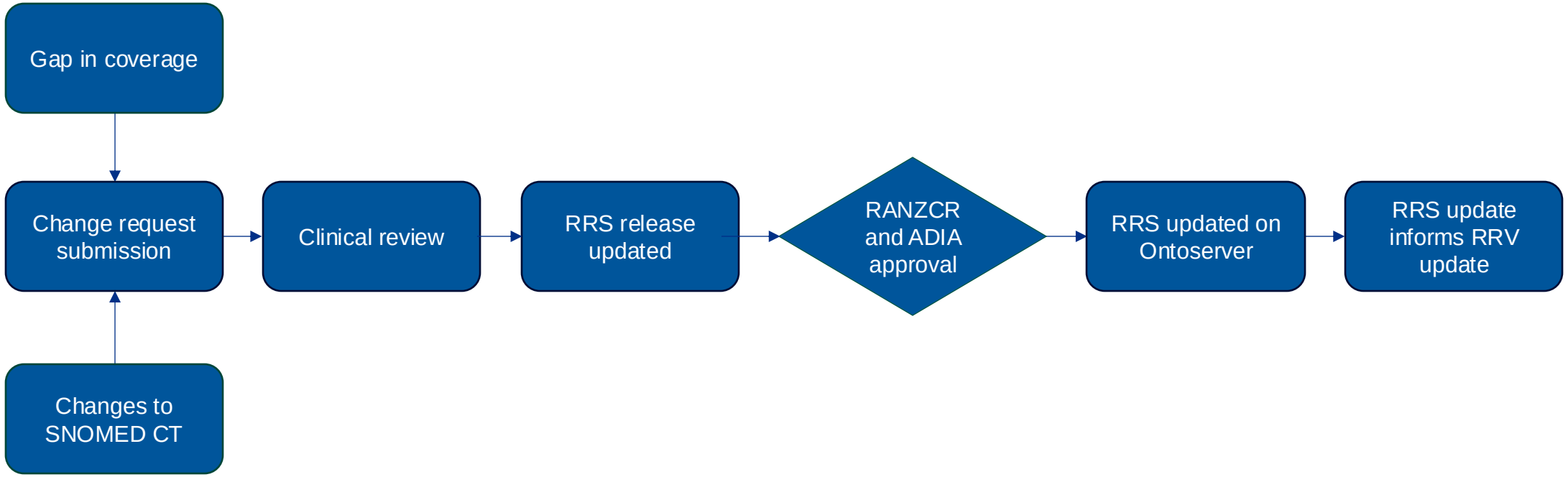
Expansion

Size: 513

version	http://snomed.info/sct|http://snomed.info/sct/32506021000036107/version/20240831
used-codesystem	http://snomed.info/sct|http://snomed.info/sct/32506021000036107/version/20240831
displayLanguage	en-US,en;q=0.9,en-AU;q=0.8
warning-draft	https://ranzcr.com/fhir/ValueSet/radiology-referral|0.1.0-ballot

Code	Display	System	Inactive	Version
45036003	Ultrasound of abdomen	http://snomed.info/sct	false	
444900008	Ultrasound of abdomen with contrast	http://snomed.info/sct	false	
418394000	Ultrasound scan of abdomen and pelvis	http://snomed.info/sct	false	
241462009	Ultrasound of abdominal aorta	http://snomed.info/sct	false	
241512001	Ultrasound of Achilles tendon	http://snomed.info/sct	false	
871000087105	Ultrasound of left Achilles tendon	http://snomed.info/sct	false	
881000087107	Ultrasound of right Achilles tendon	http://snomed.info/sct	false	
1921000087100	Ultrasound of bilateral Achilles tendons	http://snomed.info/sct	false	
431844005	Ultrasound of acromioclavicular joint	http://snomed.info/sct	false	
241480000	Ultrasound scan of adrenals	http://snomed.info/sct	false	
11691000087107	Ultrasound of left adrenal gland	http://snomed.info/sct	false	
11681000087105	Ultrasound of right adrenal gland	http://snomed.info/sct	false	

Target operating model



The Royal Australian and New Zealand College of Radiologists®

The Faculty of Clinical Radiology

ADIA

australian diagnostic imaging association

Thank you

Standards@ranzcr.edu.au

Nationally Standardised Catalogues (Pathology)

David Willock
RCPA

Pathology Information

Sparked Clinical Design Group

12 September 2024

David Willock
Digital Lead

RCPA
The Royal College of Pathologists of Australasia

RCPA
Standardised Terminology and the SPIA Guidelines

9 October, 2024

The Royal College of Pathologists of Australasia

PITUS and SPIA

- The RCPA Pathology Information, Terminology and Units Standardisation (PITUS) projects have progressed development of standardised pathology data since 2011.
- As part of the above, the RCPA has developed the Standardised Pathology Informatics in Australia (SPIA) Guidelines along with associated Information Models and Terminology Reference Sets.
- The above Reference sets are available for both Reporting and Requesting. They are downloadable from the ADHA National Clinical Terminology Service – RCPA resources
- The Requesting Ref Set is being used by the Sparked Program to provide content for the e-Requesting standard.

Standardised Pathology Information

- Providing standardised terms for the same test provides unambiguous information with surety. If standard information is being exchanged, then we can start to:
  - Improve pathology information, for example by reducing transcription errors
  - Build robust decision support, because knowledgebases that support Clinical decisions need to use the same terminology
  - Provide more accurate data analytics and research; data will not need to be converted or manipulated (often manually)
- The RCPA has a rich history in providing Terminology and other Informatics products, supporting the position that more appropriate testing benefits Consumers, Providers, Requestors and Government
- The College acknowledges the time given freely by Fellows to provide oversight and review of the SPIA content.

Standardised Pathology Information

- Benefits include
  - The inclusion of clinical and/ or historical information on pathology requests where appropriate, allowing Pathologists to provide analysis and reporting in the clinical context
  - Consumer choice (digital requests) and convenience
  - Requestors can provide digital requests easily from within the clinical workflow

- Reduction of Risk associated with
  - Transcription errors
  - Misinterpretation of data due to ambiguity of terminology
  - Laboratory variation

Standardised Pathology Information

- If you can’t find a Requesting term, you can
  - download the bulk request template from the NCTS website and
  - email your submission along with supporting documentation to help@digitalhealth.gov.au or Terminology-Support@csiro.au

- Or you can email the RCPA at pitus@rcpa.edu.au

e-Requesting and eCDS
Findings from recent work

9 October, 2024

The Royal College of Pathologists of Australasia

Recent work on e-Requesting and eCDS

- The RCPA recently finalised a project on e-requesting and e-Clinical Decision Support (eCDS).
- The draft Report has been submitted to the Department.
- Broad consultation included Pathologists, GP's, PHN's, and Medical Software providers.

Findings – e-Requesting

- Paper pathology requests will remain for many reasons, including Patient preference
- When available e-requesting is used by many GP's and can further support Requestors by providing more appropriate test list functionality, providing advice on MBS rebates/ rules, and enabling paper to be switched off
- However, e-requesting is not always used by GP's for various reasons, including the configuration at both the Requestor and Provider end; and differing configurations for different solutions
- When surveyed, feedback suggests that if a standard for e-requests was introduced it could be implemented by all PSPs within 5 years, and 76% could implement within a 3-year window

Findings e-Requesting

- 50% of the surveyed PSP's provided an e-acknowledgement of an e-Request
- Anecdotally, only 50% of pathology requests contain clinical information or the reason for the request. This is seen as the most important piece of information on a request for a PSP, to enable them to provide analysis in the clinical context
- A benefit that could be built into an e-requesting solution is the ability for the PSP to provide immediate feedback to, or seek clarification from, the requestor
- Any campaign to broaden the use of e-requesting should be funded on an ongoing period (until e-requesting is embedded) rather than a single year
- Lack of FHIR expertise is a barrier to entry for FHIR-based services for Jurisdictions (and likely others) and additionally they would benefit with assistance to model/ map terminology

eCDS Findings

- eCDS in this context is digital functionality within the Requestor workflow when requesting Pathology, to support more appropriate testing
- Whilst there was insufficient information from GP Surveys to inform a position on eCDS use, there is a suggestion that it would support *some* GP's *some* of the time.
- This was supported by GP Webinars, that is, whilst eCDS is generally supported, it will not be universally used, and when it is used, it will more likely be for complex cases.
- There remain concerns from clinicians about how eCDS will be implemented, including complexity and the drivers for implementing.

eCDS Findings

- In line with the findings from the work of the RCPA in 2015, where eCDS is introduced, there is a need to ensure:
  - Clinical autonomy for the Requestor is maintained
  - Integration within the clinical workflow
  - Content is reviewed and endorsed by both GP's (and other Requestors) and Pathologists
- Similarly, GPs need to be confident that the development and implementation of eCDS is safe, current, evidence-based, clinically lead and trusted; concerns that it may do harm must be addressed.
- GPs use a wide range of "passive" decision support tools, and the RCPA Manual is a well-recognised source of truth.

Industry perspectives

Angus Miller
Sonic Healthcare

Industry perspectives

ANGUS MILLAR
SONIC HEALTHCARE

SOFTWARE
INTEGRATION
DEVELOPER

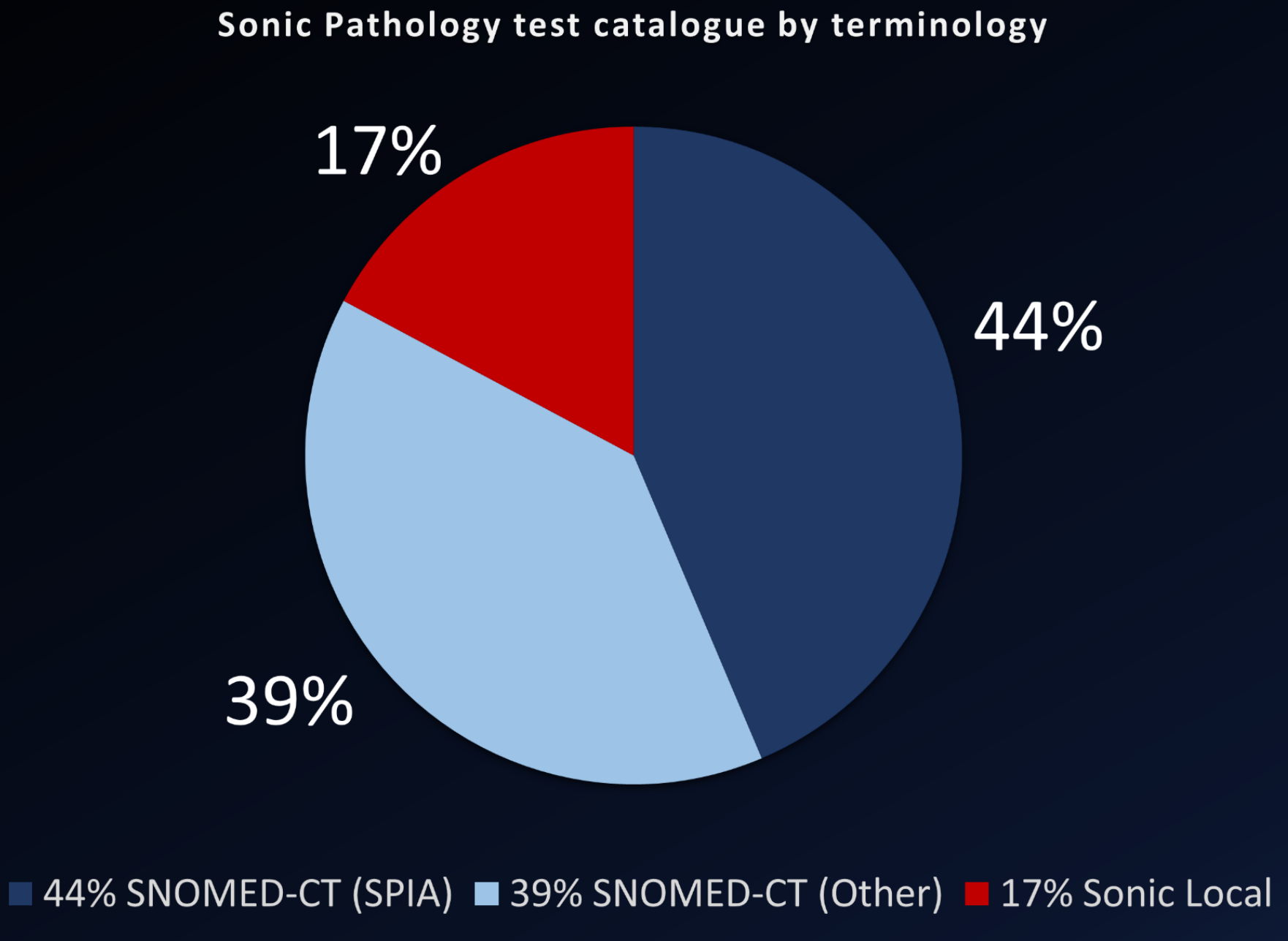
FHIR eRequesting

- Sonic’s terminology use in FHIR requesting
- Don’t get burnt, FHIR challenges and lessons learned
- FHIR publishing, what is it!

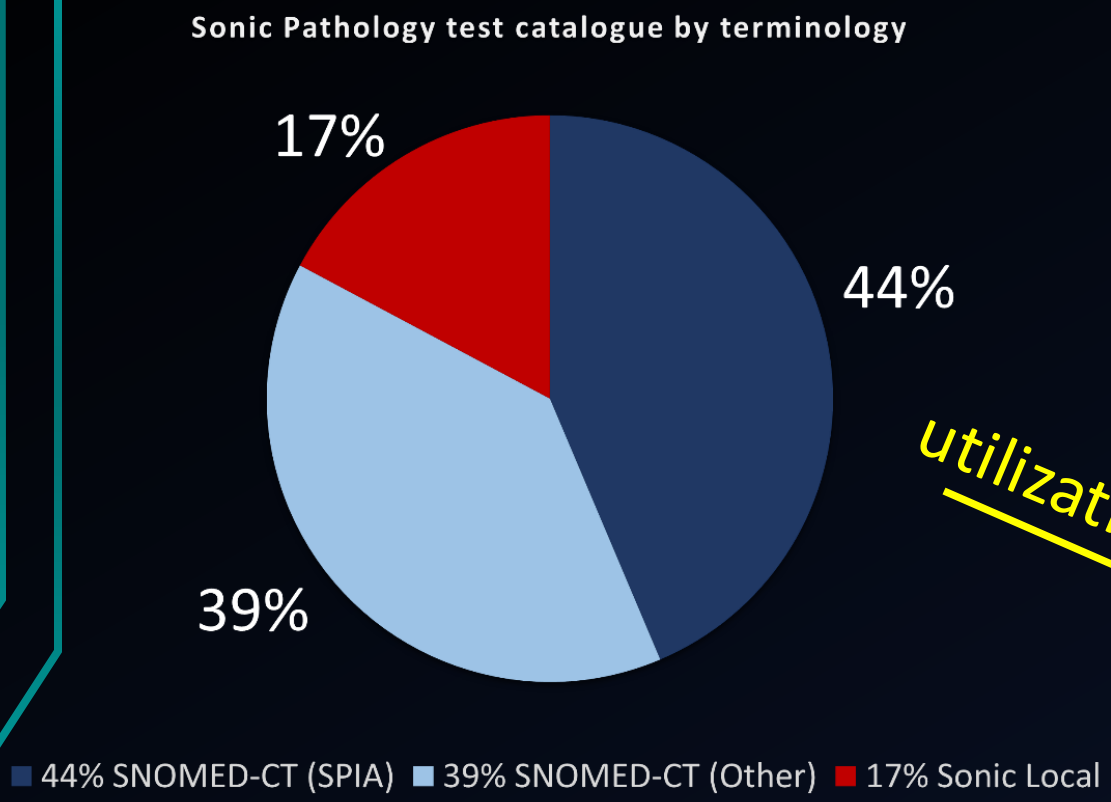
FHIR eRequesting

- SNP Live since October 2023 (All labs in February 2024)
- Real-time request status updates (*Requested, Received, With-Lab, Completed*)
- Designing the ability to acquire eRequests from third-party diagnostic provider
- Diagnostic Imaging being worked on now
- Informs Sparked eRequesting specification design
- Single SNOMED-CT requesting pathology catalogue

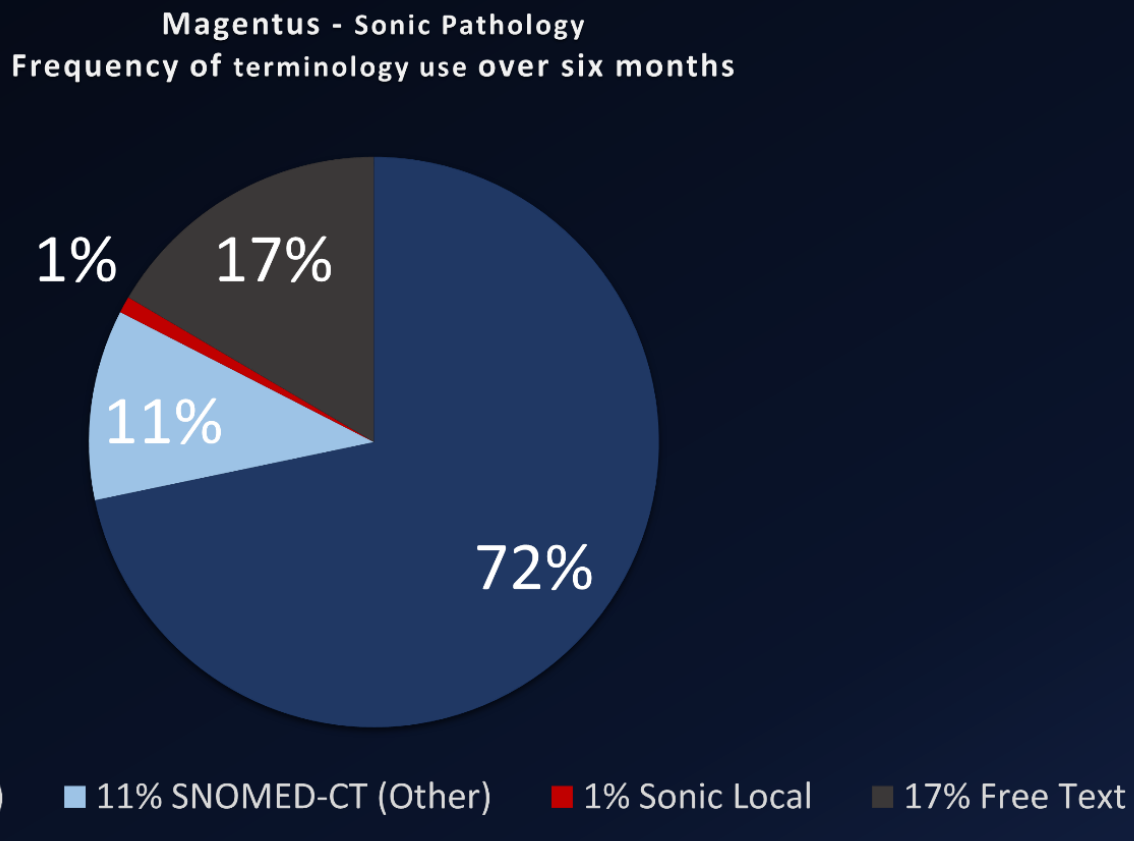
Requesting Pathology Terminology



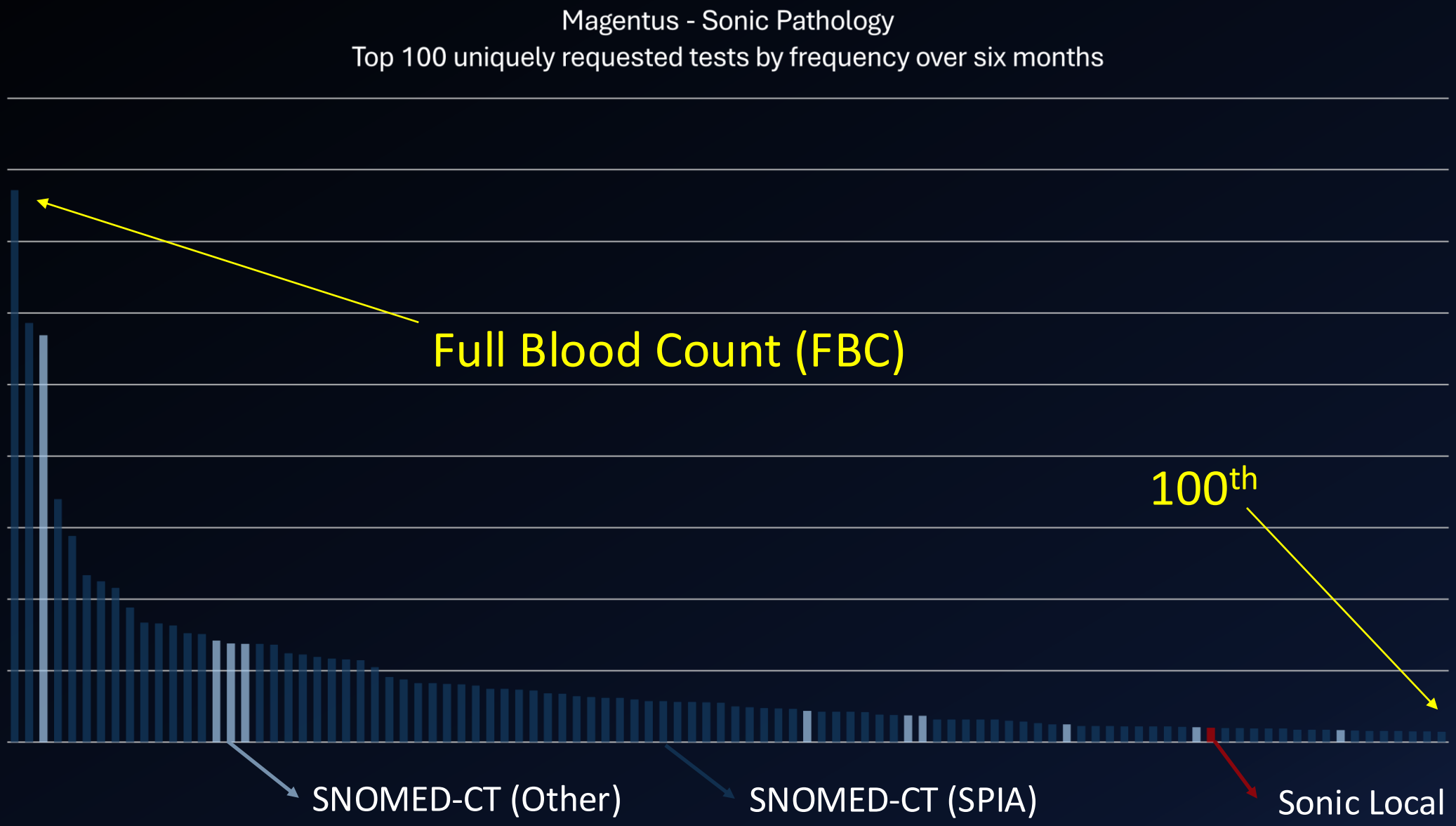
Requesting Pathology Terminology



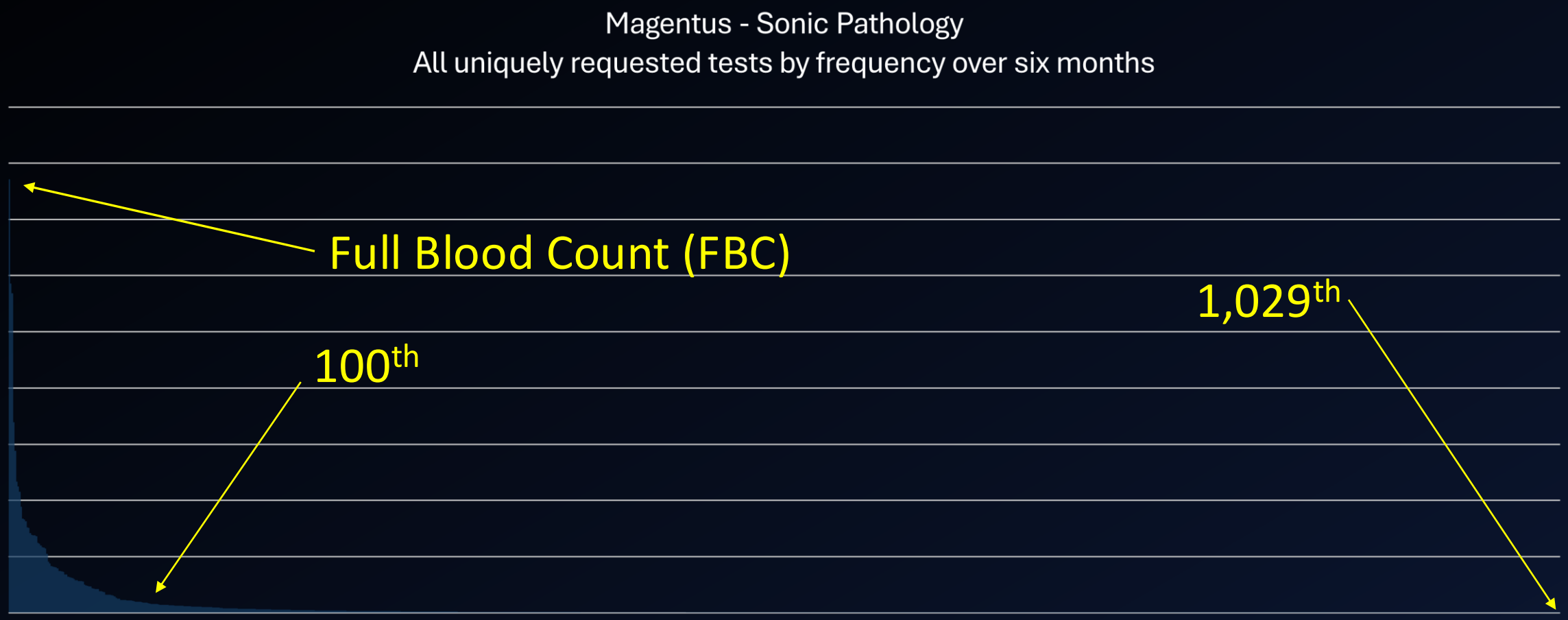
utilization



Requesting Pathology Terminology



Requesting Pathology Terminology



Cover your top 100 tests with SNOMED and you will have covered 85% of your workload

Don’t get burnt!

FHIR challenges & lessons learned

Legacy system, challenges with extra clinical information

- Legacy systems only consume minimal amounts, of very specific, structured clinical information
- No distinction between what the requester wrote in clinical notes and what was provided as structured information
- Structured data must be vetted by requester’s before being sent
- How to manage, test specific, extra clinical information

Appropriate use of ‘Free Text Tests’

Free Text Test: *HbA1c, glucose, c-peptide, UEC, CMP, LFT, FBE, B12, folate, iron studies, LDL, HDL, TG, chol, TSH, T4, vitamin D, urine ACR, BMI, GAD Ab, islet cell Ab, ZnT8 Ab*

- Creates manual work on the Laboratory
- Prone to mistakes, tests are easily missed

Technical Challenges and Insight

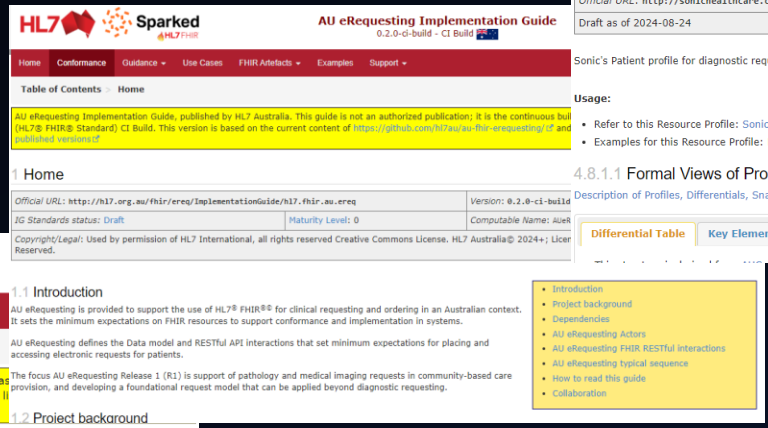
- FHIR Servers which use eventual consistency (*Performance is not everything!*)
- Verbosity of FHIR Resources
- Subscriptions/Notification/Polling vs Messaging
- Pagination of FHIR query results
- FHIR Server migration simplicity

FHIR
Its not just sending health messages

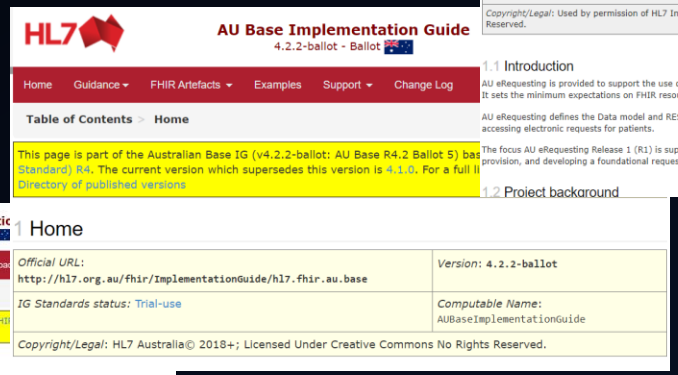
AN ENTIRE FRAMEWORK
FOR CLINICAL DATA MANAGEMENT

FHIR IG Publishing

Sonic Healthcare eRequesting

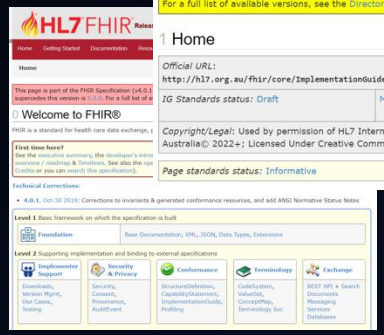


Australian eRequesting



Australian Core Standard

Australian Base Standard



HL7 International Standard

SONIC HEALTHCARE

Sonic Healthcare Australia Requesting

0.1.0 - ci-build

Home | Implementation | Resources | Artifacts | Downloads

Table of Contents > **Artifacts Summary**

Sonic Healthcare Australia Requesting - Local Development build (v0.1.0) built by the FHIR (HL7® FHIR® Standard) Build Tools. See the Directory of published versions

4 Artifacts Summary

This page provides a list of the FHIR artifacts defined as part of this implementation guide.

Contents:

4.0.1 Structures: Abstract Profiles

These are profiles on resources or data types that describe patterns used by other profiles, but cannot be instantiated directly. I.e. instances can conform to profiles *based* on these abstract profiles, but do not declare conformance to the abstract profiles themselves.

Sonic Service Request Abstract	Sonic's abstract base ServiceRequest resource profile
Sonic Task Fulfillment Abstract	Sonic Task Fulfillment Abstract Profile
Sonic Task Fulfillment Group Abstract	Sonic Task Fulfillment Group Abstract Profile

4.0.2 Structures: Resource Profiles

These define constraints on FHIR resources for systems conforming to this implementation guide.

Sonic Consent	My Health Record Consent Withdrawl
Sonic Coverage	Sonic Coverage Profile
Sonic Encounter	Sonic Encounter (Transistent Encounter for the context of the diagnostic request)
Sonic Organization	Sonic Organization
Sonic Patient	Sonic's Patient profile for diagnostic requesting
Sonic Practitioner	Sonic Practitioner Profile
Sonic PractitionerRole	Sonic PractitionerRole Profile
Sonic ServiceRequest Imaging	Sonic ServiceRequest Imaging Profile
Sonic ServiceRequest Pathology	Sonic ServiceRequest Pathology Profile
Sonic Task Fulfillment Imaging	Sonic Task Fulfillment Imaging Profile
Sonic Task Fulfillment Imaging Group	Sonic Task Fulfillment Imaging Group Profile
Sonic Task Fulfillment Pathology	Sonic Task Fulfillment Pathology Profile
Sonic Task Fulfillment Pathology Group	Sonic Task Fulfillment Pathology Group Profile

SONIC HEALTHCARE

Sonic Healthcare Australia Requesting

0.1.0 - ci-build

Home | Implementation | Resources | Artifacts | Downloads

Table of Contents > **Downloads**

Sonic Healthcare Australia Requesting - Local Development build (v0.1.0) built by the FHIR (HL7® FHIR® Standard) Build Tools. See the Directory of published versions

3 Downloads

3.1 Downloadable copy of entire specification

A downloadable version of the entire implementation guide as a website is available so it can be hosted locally.

It is not recommended to view locally without hosting, but you can extract the files and open the index.html file in a web browser. This will provide access to the table of contents, introduction, and navigation links to different sections of the implementation guide.

- Downloadable Copy

3.2 Package file

The following package file includes an NPM package file used by many of the FHIR tools. It contains all the value sets, profiles, extensions, list of pages and urls in the IG, etc defined as part of this version of the Implementation Guides. This file should be the first choice whenever generating any implementation artefacts since it contains all of the rules about what makes the profiles valid. Implementers will still need to be familiar with the content of the specification and profiles that apply in order to make a conformant implementation:

- R4 Package
- R4B Package

See the overview on validating FHIR profiles and resources for more information about validating profiles and how to use these artefacts.

3.3 Examples

All examples included in this implementation guide are available for download:

4.8.1.1 Formal Views of Profile Content

Description of Profiles, Differentials, Snapshots and how the different presentations work.

Differential Table | Key Elements Table | Snapshot Table | Statistics/References | All

properties

This structure is derived from AUCorePatient

Name	Flags	Card.	Type	Description & Constraints
Patient			AUCorePatient	
id	S	0..1	id	Logical id of this artifact
Slices for identifier				Content/Rules for all slices
identifier:mrn	S	0..1	AUMedicalRecordNumber(4.2.2-ci-build)	Identifies this patient across multiple systems
identifier:insurancemember	S	0..1	AUInsuranceMemberNumber(4.2.2-ci-build)	Identifies this patient across multiple systems
type				
coding		1..1	Coding	Code defined by a terminology system
active	S	1..1	boolean	Whether this patient's record is in active use
Slices for name		*1..**	*HumanName*	*A name associated with the patient* ***Slice:*** *Unordered, Closed by value:use*
name:official	S	1..1	HumanName	A name associated with the patient
use		1..1	code	usual | official | temp | nickname | anonymous | old | maiden **Fixed Value:** official
family		1..1	string	Surname
given		1..2	string	Given and middle names
prefix		0..1	string	Title
Slices for telecom		*0..**	*ContactPoint*	*A contact detail for the individual* ***Slice:*** *Unordered, Closed by value:use, value:system*
telecom:mobile	S	0..1	ContactPoint	A contact detail for the individual
system		1..1	code	phone | fax | email | pager | url | sms | other

FHIR IG Publishing

FHIR Publisher

Sushi

Sonic FSH

Sparked AU eRequesting

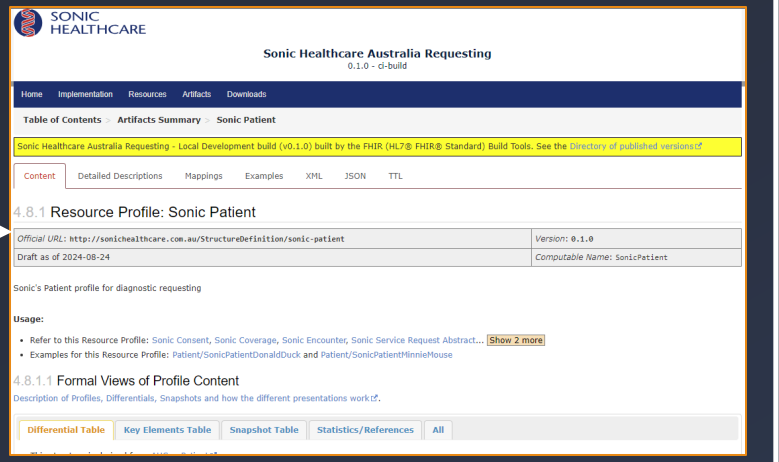
Sparked AU Core

Sparked AU Base

International FHIR

www.sonichealthcare.com.au/fhir-requesting

Sonic FHIR IG Artefacts



External Sonic Implementer

Sonic Patient Resource

Sonic FHIR IG Artefacts

FHIR Validator

Is Valid: Ok

Is Valid: Fail

Deep Dive with FSH by Chris Moesel
https://fshschool.org/courses/fsh-seminar/04-deep-dive-with-fsh.html

FSH School
https://fshschool.org/FSHOnline

IG Publisher Documentation
https://confluence.hl7.org/display/FHIR/IG+Publisher+Documentation

Industry perspectives

Jess White

Best Practice

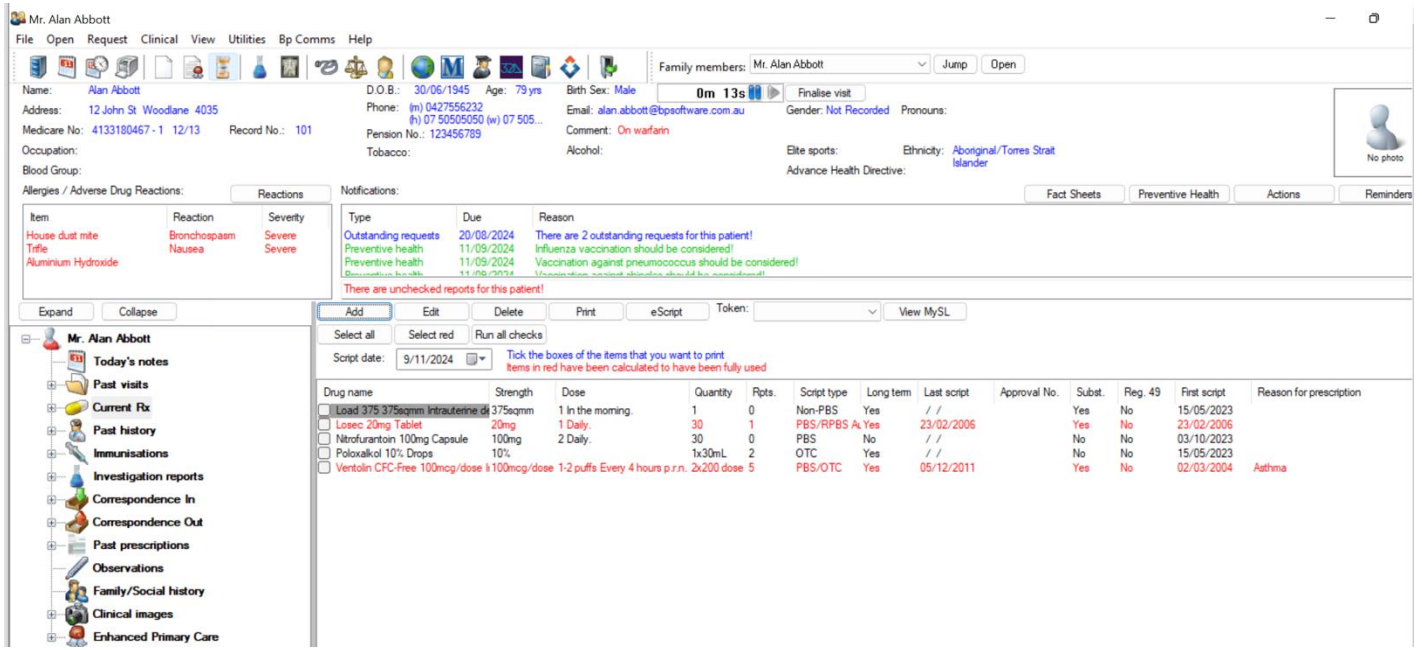
eRequesting – An Industry Perspective

Jess White
Best Practice Software

A bit about Best Practice Software

- Australian Medical Software Provider
- Established in 2004

- We Currently support :
  - Over 6000 Primary Healthcare Clinics
  - Over 40,000 Clinicians
  - 100k + end users
  - 200 eco-system Partners
  - 50 eOrdering Partners

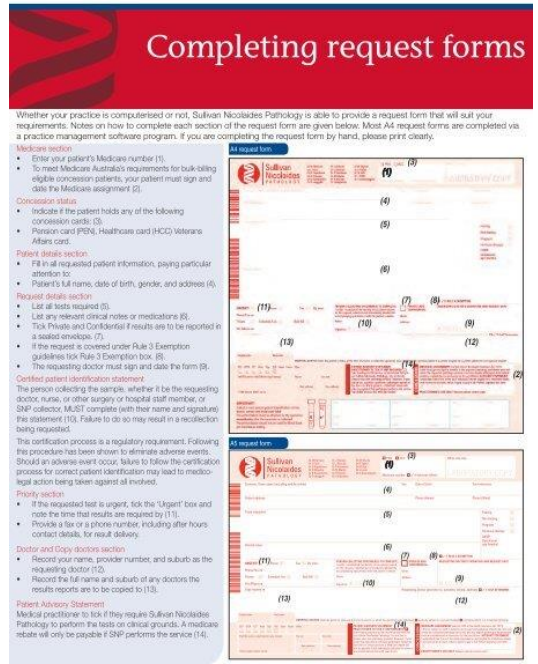


Bp Premier

Current Challenges

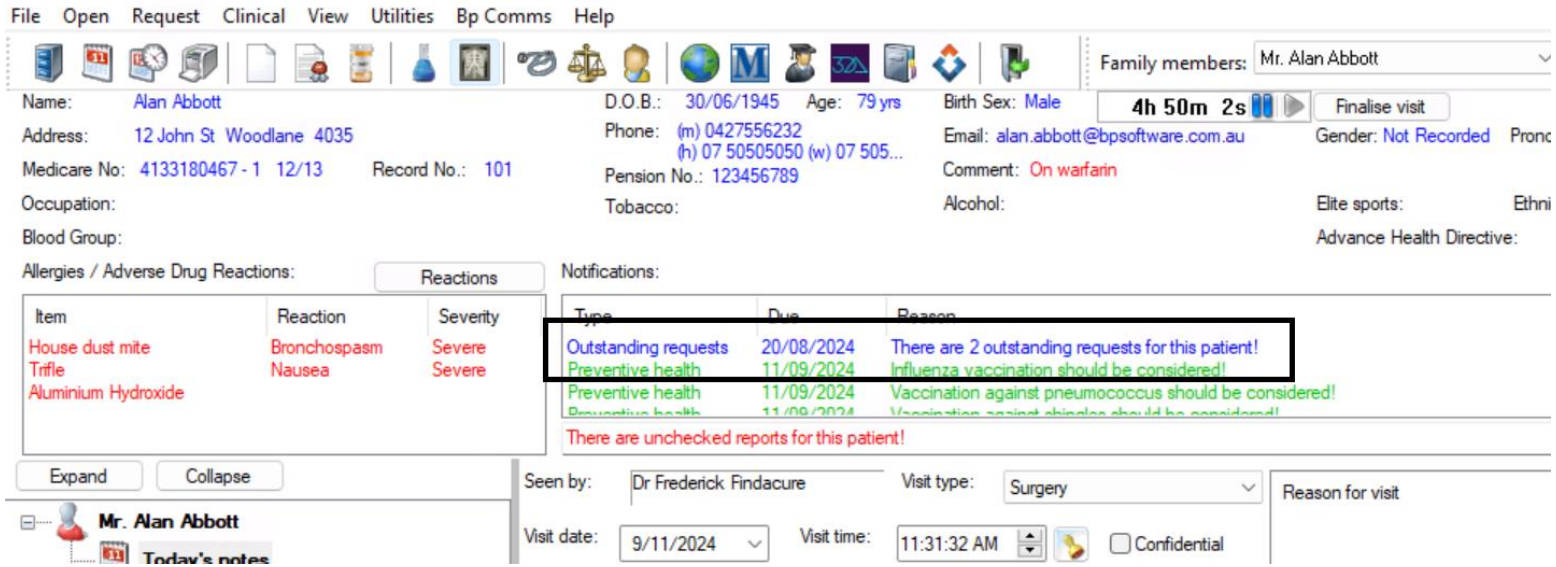
HTML

Lots of These!



Diagnostic Imaging Test Lists!

Current Challenges



01

For Best Practice Software:

Supporting and managing multiple e-Ordering Test Lists

- Supporting the importing of different result formats
- Multiple areas of our software need manual data entry

02

For Customers:

- Installation of Multiple messaging brokers
- Address Book Management
- No standard test lists or terminology being used between existing providers
- Manual data entry required in EMR due to inconsistency of reporting

03

For Industry:

- Each software vendor may require different technical requirements for result import and send
- Referrer Education Needed
- $$$ to pay a messaging broker to transmit results

Clinical Decision Support

- Guidance Based Requesting
- Recommended Tests

Real-time access to data

- Removing need for messaging brokers, reduces send and delivery risks
- Access to what tests have been previously done and when?

eRequesting Uptake

- Reduce current administrative burden managing requests
- Reduce transcription errors
- Reduce overheard on Clinicians (Re-print requests!)

Data Standards

- Consistent requesting terminology = better requesting + reporting

Questions?

Jessica White
Best Practice Software
Jessica.White@bpsoftware.net

Department of Health and Aged Care

Jeremy Sullivan

Morning tea

Back at 11:00am

Accenture
Grant Carter

Updating Pathology Test Name Diversity

MHR Discovery

August 2024

accenture

Australian Government
Australian Digital Health Agency

My Health Record

MHR Pathology test name diversity

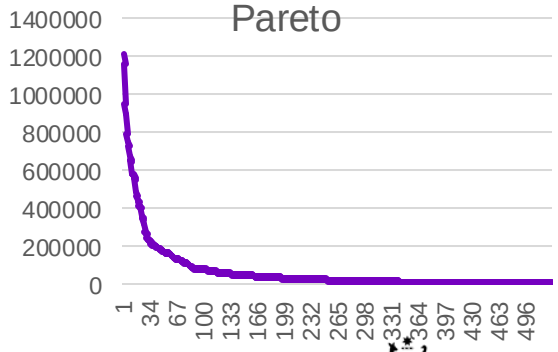
- For **one month** period May-Aug 24
  - 34,016 unique test result names

    One LIS contributes most of the variation
  - 44,673,497 total test uploads
  - Low coding rates

    0.3% SNOMED

    mainly COVID PCR
  - Top ~30 →

90%+ of actual distinct tests occur in the top 30, but Pareto has a *very long tail!*



Row Labels	Sum of COUNT_OF_REPORTS
FULL BLOOD COUNT	1,212,426
FULL BLOOD EXAMINATION	1,162,839
Urea, electrolytes and creatinine measurement	949,397
GENERAL CHEMISTRY	893,801
ROUTINE HAEMATOLOGY	794,287
C-REACTIVE PROTEIN	752,582
GENERAL BIOCHEMISTRY	725,141
IRON STUDIES	679,416
LIPID STUDIES	658,076
THYROID FUNCTION TEST	652,299
HAEMATOLOGY	584,997
Liver function tests - general	583,017
E/LFT (MASTER)	580,994
MASTER FULL BLOOD COUNT	563,369
Routine Biochemistry	557,238
Total serum calcium, magnesium and phosphate measurement	487,754
Point of Care Testing	461,458
SERUM CHEMISTRY	444,875
Haematology: Complete Blood Examination	433,228
C-reactive protein measurement	417,719
FULL BLOOD PICTURE	411,613
GLUCOSE	409,203
LIVER FUNCTION TESTS	365,685
IFOBT PAT	351,001
S-_ROUTINE CHEMISTRY	347,566
.BLOOD COUNT	323,621
VITAMIN D	276,961
MASTER IRON STUDIES	273,884
THYROID TEST MASTER	267,934

FULL BLOOD COUNT	1,212,426
FULL BLOOD EXAMINATION	1,162,839
MASTER FULL BLOOD COUNT	563,369
FULL BLOOD PICTURE	411,613
Full Blood Count Comment	2,146
Full Blood Picture (POCT)	6

GENERAL CHEMISTRY	893,801
GENERAL BIOCHEMISTRY	725,141
Routine Biochemistry	557,238
SERUM CHEMISTRY	444,875
S-_ROUTINE CHEMISTRY	347,566
Protein Chemistry	198,662
Chemistry: Ca Ion Calc, ECU LFT CAL PHO URA GL, eGFR	90,789
Biochemistry	29,063

accenture

Australian Government
Australian Digital Health Agency

MHR Pathology common panel categories

All MyHR Path CDA uploads to August 2022		112,521,933
Panels		
Lipids		
	lipids	1,770,566
	Cholesterol (not in lipid panel)	47,440
	Triglycerides (not in lipid panel)	28,103
		1,846,109
EUC (UEC)		
	Chemistry	8,757,122
	UEC	161,623
	EUC	661
		8,919,406
Hepatic (LFT)		
	Liver	3,060,267
	LFT	1,411,151
		4,471,418
Full Blood Count		
	Full blood	9,202,820
	Blood count	365,244
	FBC	137,343
		9,705,407
Iron Studies		
	Iron	2,068,834
	Fe	30,283
		2,099,117
TFT	Thyroid	1,983,138
	TFT	226,709
		2,209,847

~ 30% of all tests

MHR Pathology common tests released within 7 days

Tests			
INR			
		INR	187,617
		International normalised ratio	391,637
		SA (from Haemostasis and Thrombosis)	98,529
			677,783
HBA1C			
		HBA1C	806,329
		SA Hba1C	301,466
			1,107,795
Glucose			
		Glucose (any body fluid, GTT, G6PD)	**1,867,570**
Covid			
		nucleic acid or serology	**4,369,420**
RSV			
		RSV	81,848
		Resp sync	888
			82,736
HBsAG			
		Hep. Hep B various	**850,000**

MHR Pathology test panel diversity – LIS specific e.g.

- For one month period May-Aug 24
  - 6,328 unique Chemistry panel variants from single LIS (Cerner)
  - Format is panel (eg Chemistry: followed by a variant list of tests performed in the panel

But list is limited to 80 characters

  - Top ~30 →

Row Labels	Sum of COUNT_OF_REPORTS
Chemistry: Ca Ion Calc, ECU LFT CAL PHO URA GL, eGFR	90,789
Chemistry: Ca Ion Calc, eGFR, ECU LFT CAL PHO URA GL	43,315
Chemistry: ECU LFT CAL PHO URA GL, Ca Ion Calc, eGFR	31,447
Chemistry: Glucose	31,182
Chemistry: POC Blood Gas Arterial	27,557
Chemistry: POC Blood Gas Venous	24,422
Chemistry: ECU LFT CAL PHO URA GL, Ca Ion Calc, eGFR, Magnesium	23,643
Chemistry: Ca Ion Calc, eGFR, ECU LFT CAL PHO URA GL, Magnesium	21,387
Chemistry: Ca Ion Calc, ECU LFT CAL PHO URA GL, eGFR, Magnesium	20,783
Urine Chemistry: Creatinine	17,754
Chemistry: eGFR, Ca Ion Calc, ECU LFT CAL PHO URA GL	15,299
Chemistry: Ca Ion Calc, ELE URE CRE CA MG PHO LFT, eGFR	13,519
Chemistry: Electrolytes, Urea, Creatinine, eGFR	12,769
Chemistry: ELEC CREA UREA LFT, eGFR	12,149
Chemistry: eGFR, Electrolytes, Urea, Creatinine	10,596
Chemistry: Ca Ion Calc, eGFR, ELE URE CRE CA MG PHO LFT	10,374
Chemistry: Ca Ion Calc, ECU LFT CAL PHO URA GL, Magnesium, eGFR	10,343
Chemistry: eGFR, Ca Ion Calc, ECU LFT CAL PHO URA GL, Magnesium	8,981
Chemistry: ECU LFT CAL PHO URA GL, eGFR, Ca Ion Calc	7,143
Chemistry: ECU LFT CAL PHO URA GL, eGFR, Magnesium	7,141
Chemistry: ECU LFT CAL PHO URA GL, eGFR	6,438
Chemistry: eGFR, ELEC CREA UREA LFT	6,218
Urine Chemistry: Protein Creatinine Ratio, Creatinine	5,200
Chemistry: ECU LFT CAL PHO URA GL, Ca Ion Calc, Magnesium, eGFR	5,025
Point of Care - Chemistry: Point of Care - CG4, Point of Care - Chem 8	4,339
Immunochemistry: Protein Electrophoresis	3,950

MHR Pathology synonyms, non-specific “&junk” test names

- For one month period

  May-Aug 24

  – “Junk” examples

HL7 Mask for iSTAT
HL7 Mask for XBBIOA
HL7 Mask for XBC3N
HL7 Mask for XBMAG
HL7 Mask for XBUOA
HL7 Mask for XXBFLU
HL7 Mask for XXBGEN
HL7 Mask for XXBTUM
HL7 Mask for XXBURC
HL7 Mask for XXBUTX

REPORT TO DOCTOR
Surgical Pathology
DOCTORS UDS
Laboratory
U-DOCTORS UDS
Outside Lab
No doctor signature
Outside Lab

REFERRED TO MDU
REFERRED TO MELB. HEALTH
REFERRED TO MND
REFERRED TO MONASH
REFERRED TO MONASH UNI
REFERRED TO PATHWEST FSH

SENDAWAY TEST
SENDAWAY TEST 2

RECOLL.INAPPROPRIATE CODE
RECOLLECT
RECOLLECT BUN
RECOLLECT CC
RECOLLECT CC1
RECOLLECT DR
RECOLLECT MAIN
RECOLLECT NOT DONE
RECOLLECT NOTIF
RECOLLECT NOTIF2
Recollection
RECOLLECTS
RECOLLECTS

Synonym variants

HIV EIA
HIV FURTHER TESTING
HIV geno drug resist
HIV GENOTYPE
HIV GENOTYPE &DRUG RESIST
HIV GENOTYPE SENDAWAY
HIV Genotype Sendaway Page 1/2
HIV INSURANCE/COMMERCIAL
HIV LOAD ULTRA SENS
HIV P24 ANTIGEN
HIV PROVIRAL DNA
HIV PRO-VIRAL DNA
HIV Proviral DNA NAT
HIV RNA
HIV RNA GENOTYPING
HIV RNA/VIRAL LOAD
HIV SEROLOGY

.GH 0
.GH 120
.GH 150
.GH 180
.GH 30
.GH 45
.GH 60
.GH 75
.GH 90

HEP C GENO/SUBTYPE
HEP C GENOTYPE
HEP C GENOTYPING
HEP C PCR (QUALITATIVE)
HEP C PCR IMVS
HEP C PCR QUAL
Hep C RNA - PCR
Hep C RNA (PCR)

Service category variances e.g.

Contains cytopathology	Total
Surgical Pathology	2,140
Cytopathology	1,864

FULL BLOOD COUNT
Chemistry
Hematology

IRON STUDIES
Chemistry
Hematology
Laboratory

HBA1C
Blood Bank
Chemistry
Hematology
Laboratory

MHR Meaningful clinical use proxy (clinical view downloads)

MHR Clinical View downloads		
Per annum		
18,913,232	Path views	
16,457,376	Meds views	
17,711,408	DI Views	
12,610,208	MOV Views	
8,591,024	Hro Views	
2,245,516	MCV's	New view, extrapolated
734,916	CIV's	
158,912	My GP	

Meds view testimonial: A single document with everything I need about a patient's medications, easy to read, easy to download and incredibly useful. Absolutely brilliant
-Too good to be true but it is! Please pass on my thanks to the team who developed it

Meds view generally well accepted, but…

- May not (always) contain private scripts, OTCs
- Patient may opt-out of PBS uploads
- Historical issues with PBS claim identity (very low %)
- PSML & RSMC are unfortunately PDFs
- AMT coded clinical documents (other than Dr, Pr) still infrequent
- Colours, fixed columns, advisories not liked by all
- FHIR API still not released

MHR Path view test name grouping example

View generated on 15-Mar-2022 16:49

Reports - grouped by Test Name and ordered by Specimen collection date

09-Apr-2021 to 16-Apr-2021 (11 months ago)

Organisation	Specimen collected date	Time	Test name	Status	Report	Report group
Medical Laboratories	16-Apr-2021 (11 months ago)	22:12	**BIOCHEMICAL ANALYSIS**	Final	1st Report	(View 45 more within 6 days)
		22:12	**General Chemistry**	Final	1st Report	(View 52 more within 6 days)
		18:00	**Full Blood Count**	Final	1st Report	(View 7 more within 6 days)
Medical Laboratories	15-Apr-2021 (11 months ago)	18:30	**Faecal Pathogens PCR**	Final	1st Report	(View 1 more on the same day)
Medical Laboratories	14-Apr-2021 (11 months ago)	19:30	**Coagulation Profile**	Final	1st Report	(View 5 more within 4 days)
		18:20	**Screen MRSA/VRE/ESBL**	Final	1st Report	(View 1 more within 3 days)
		18:20	**Sputum MCS**	Final	1st Report	(View 1 more within 4 days)
		18:20	**Urine MCS**	Final	1st Report	(View 2 more within 4 days)
Medical Laboratories	12-Apr-2021 (11 months ago)	11:20	**Catheter - Vascular**	Final	Report	
Medical Laboratories	11-Apr-2021 (11 months ago)	17:55	**Thyroid Studies**	Final	Report	
		12:30	**Blood Cultures**	Final	1st Report	(View 2 more within 4 days)
Medical Laboratories	10-Apr-2021 (11 months ago)	23:55	**Surgical Pathology**	Final	1st Report	(View 1 more on the same day)
		23:45	**Blood Bank Tests**	Final	Report	
		23:40	**General Cytology**	Final	1st Report	(View 1 more within 1 day)
Medical Laboratories	09-Apr-2021 (11 months ago)	12:00	**Bronchial Lavage MCS**	Final	1st Report	(View 1 more on the same day)

Medsview – PBS and Prescription derived unique ingredient view

Medicines Preview - Latest Documents, PBS Claims, Dispenses, Prescriptions with no later dispenses - sorted by descending event date.
15-Jul-2013 to 25-Nov-2016 (6 months ago)

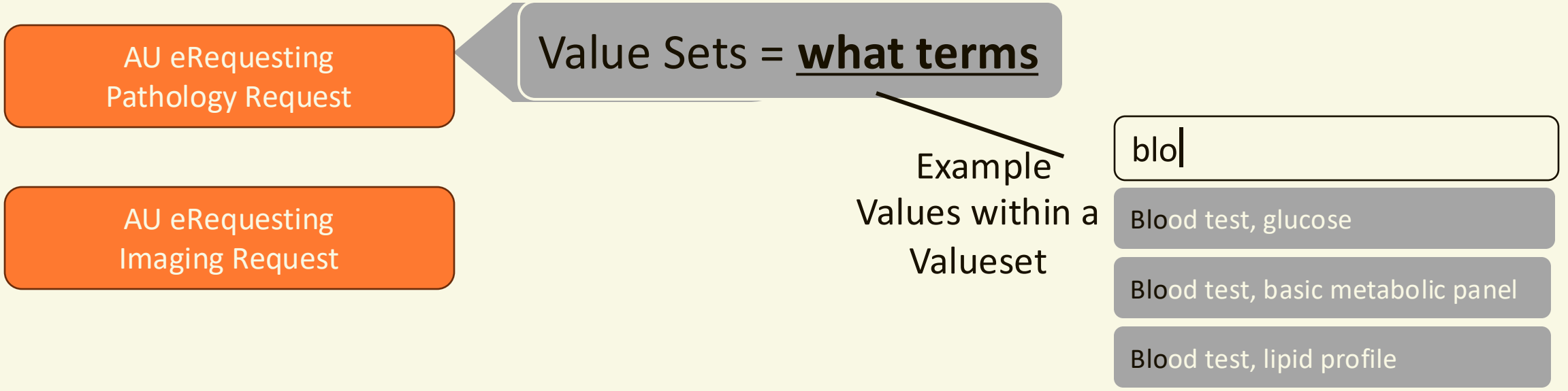
Source/Author	Date	Medicine - Active Ingredient(s)	Medicine - Brand	Directions
Latest dispense	25-Nov-2016 (6 months ago) (11 dispenses in 3 years)	**FLUTICASONE + SALMETEROL**	SERETIDE MDI 250/25 250MCG/ACTUATION + 25MCG/ACTUATION INHALATION: PRESSURISED, 120 ACTUATIONS	Prior Prescription Record was SERETIDE MDI 250mcg-25mcg/dose INHALER dose 2 puffs b.d. rinse mouth after use
Latest dispense	25-Nov-2016 (6 months ago) (61 dispenses in 3 years)	**MACROGOL-3350 + SODIUM CHLORIDE + POTASSIUM CHLORIDE + BICARBONATE**	MOLAXOLE 13.12G + 350.7MG + 46.6MG (0.63 MMOL POTASSIUM) + 178.5MG SOLUTION, 30 SACHETS	Prior Prescription Record was MOVICOL 13.125g/350.7mg/178.5mg/46.6mg SACHET dose 1 nocte for bowel motion
Latest dispense	25-Nov-2016 (6 months ago) (26 dispenses in 3 years at 3 forms/strengths)	**MIRTAZAPINE**	MIRTAZON MIRTAZAPINE 30MG TABLET, 30 Dispense Claim differs 2 months before as MIRTAZAPINE-GA MIRTAZAPINE 45MG TABLET, 30 Dispense Claim differs 17 months before as AXIT 15 MIRTAZAPINE 15MG TABLET, 30	Prior Prescription Record was MIRTAZAPINE 30mg TABLET dose 1/2 nocte for sleep and mood
Latest dispense	25-Nov-2016 (6 months ago) (29 dispenses in 3 years)	**PARACETAMOL**	OSTEOMOL 665 PARACETAMOL PARACETAMOL 665MG TABLET: MODIFIED RELEASE, 96 TABLETS	Prescription on same day is not available.
Latest dispense	25-Nov-2016 (6 months ago) (5 dispenses in 3 years)	**SALBUTAMOL**	ASMOL CFC-FREE SALBUTAMOL 100MCG/ACTUATION INHALATION: PRESSURISED, 200	Prior Prescription Record was VENTOLIN CFC-FREE 100mcg/dose INHALER dose 2 puffs b.d. when required for shortness of breath/wheeze
Latest dispense	23-Nov-2016 (6 months ago) (45 dispenses in 3 years)	**ISOSORBIDE MONONITRATE**	MONODUR 120MG ISOSORBIDE MONONITRATE 120MG TABLET: MODIFIED RELEASE, 30 TABLETS	Prior Prescription Record was IMDUR 120mg SR TABLET dose 1 mane for angina
Latest dispense	23-Nov-2016 (6 months ago) (23 dispenses in 3 years)	**PERHEXILINE**	PEXSIG PERHEXILINE MALEATE 100MG TABLET, 100	Prior Prescription Record was PERHEXILINE MALEATE 100mg TABLET dose 1 b.d. for angina
Latest dispense	14-Nov-2016 (7 months ago) (49 dispenses in 3 years at 2 forms/strengths)	**WARFARIN**	MAREVAN WARFARIN SODIUM 1MG TABLET, 50 Dispense Claim differs 10 months before as MAREVAN WARFARIN SODIUM 3MG TABLET, 50	Prior Prescription Record dose as directed, thins blood
Latest dispense	12-Nov-2016 (7 months ago) (29 dispenses in 2 years)	**DUTASTERIDE + TAMSULOSIN**	DUODART 500UG/400UG DUTASTERIDE 500MCG + TAMSULOSIN HCL 400MCG CAP: MODIFIED RELEASE, 30	Prior Prescription Record was DUODART 500mcg/400mcg SR CAPSULE dose 1 daily for bladder/prostate
Latest dispense	08-Nov-2016 (7 months ago) (44 dispenses in 3 years)	**NICORANDIL**	IKOTAB NICORANDIL 20MG TABLET, 60	Prior Prescription Record was IKOREL 20mg TABLET dose 1 b.d. for angina

NSW Health Pathology
Juliana Iles-Mann

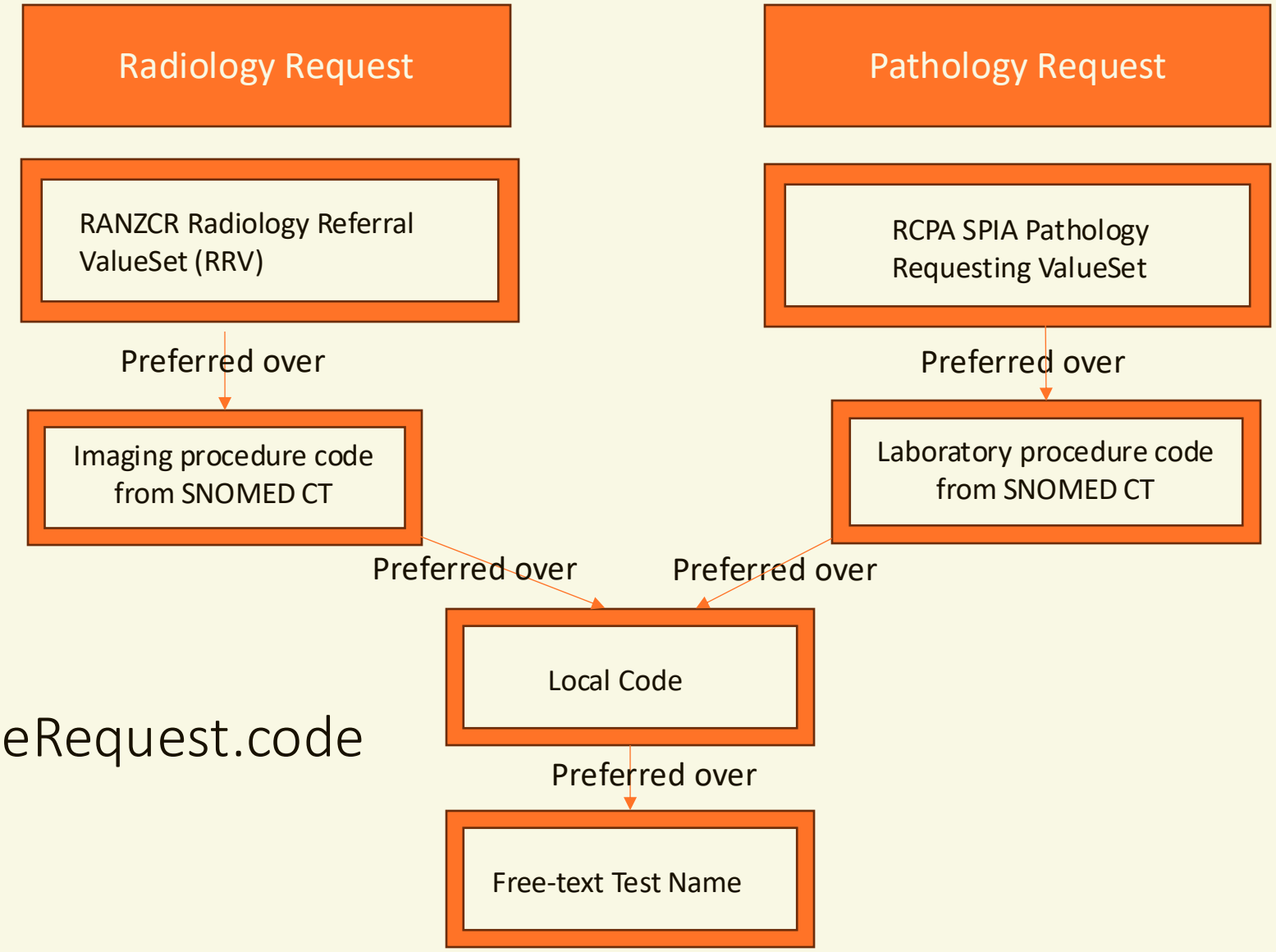
Workshop 2: Validate eRequesting terminology

FHIR Terminology

- The connection between a data element and a specific set of standardised codes or terms.
- Ensures that everyone uses the same terms & codes, improving consistency and communication.



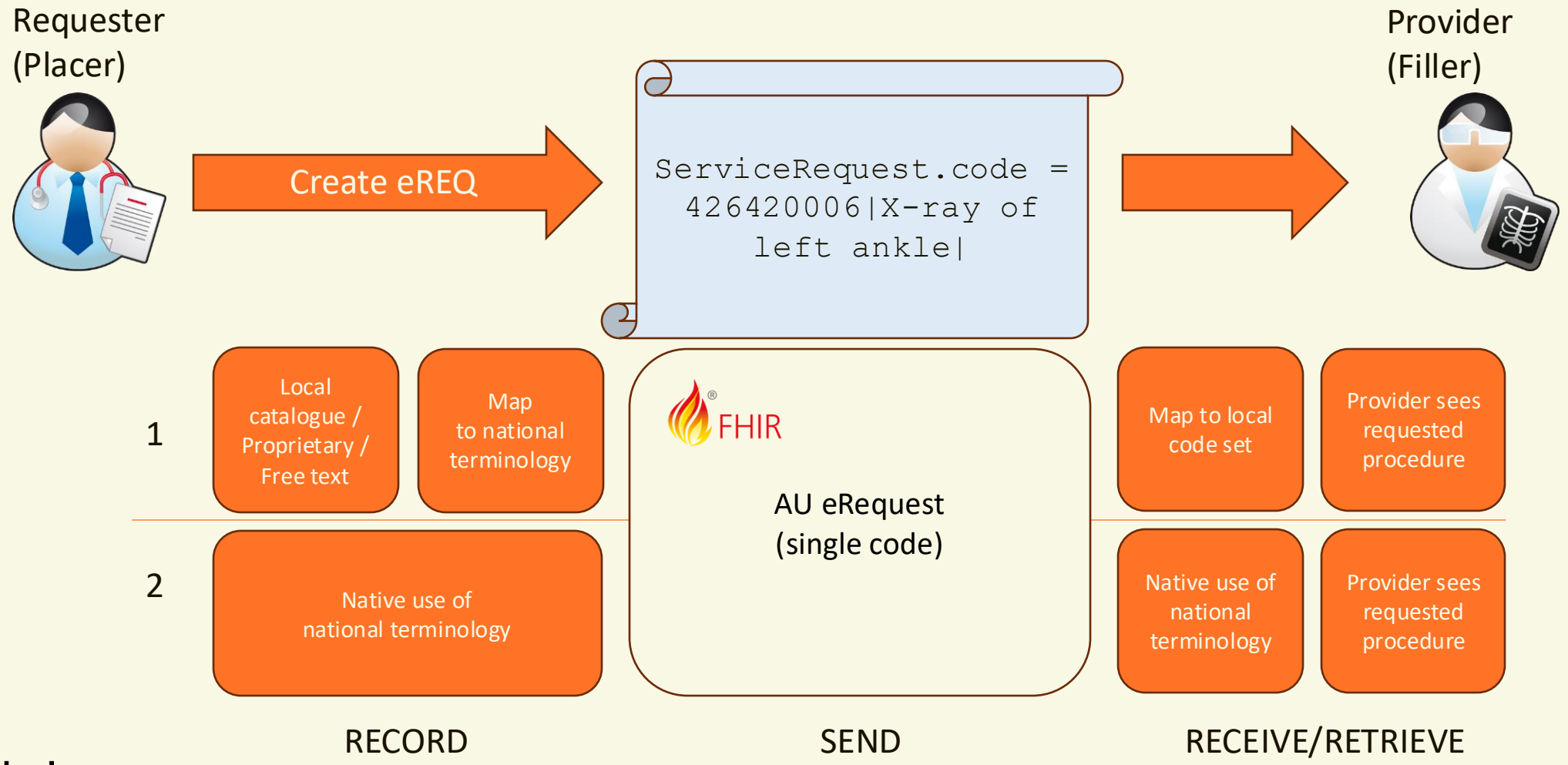
Starting point for consensus



Agreed ServiceRequest.code binding

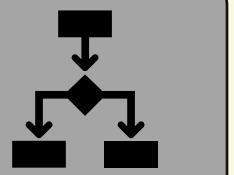
Sparked HL7 FHIR

eRequesting – example information pathways



Sparked HL7 FHIR

eRequest workflow - Demo context



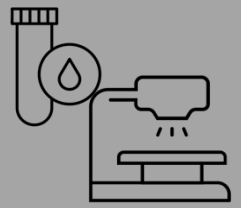
Decision for request

Generate request

Consumer selects & books provider

Provider receives request

Request successfully accepted



Test/scan is performed

Fulfilment complete

Results available

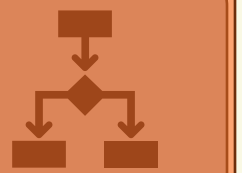
In scope for R1

Out of scope for R1

Sparked

HL7 FHIR

eRequest workflow - Demo context



Decision for request

Generate request

Consumer selects & books provider

Provider receives request

Request successfully accepted

Test/scan is performed

Fulfilment complete

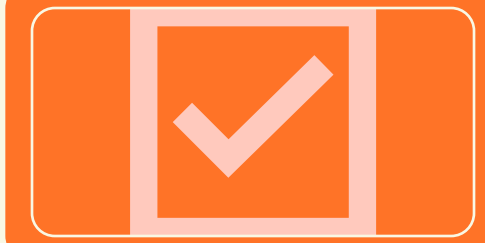
Results available

In scope for R1

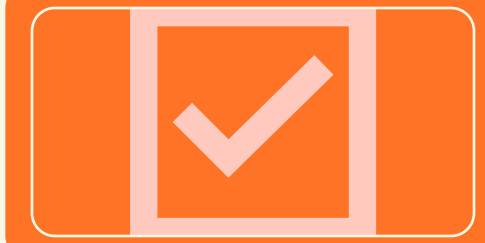
Out of scope for R1

Sparked
HL7 FHIR

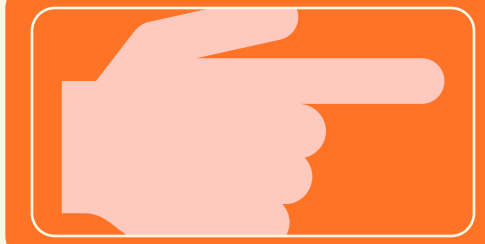
Demo context - Request Selection



Identified request/s



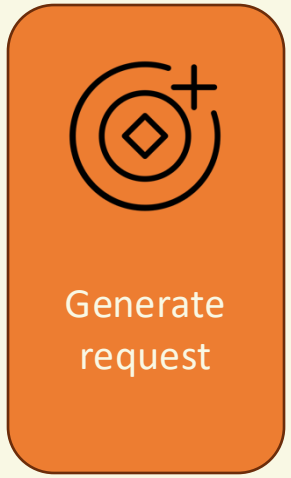
Completed most of eRequesting form



Select the request

Sparked
HL7 FHIR

eRequest demo scope



Pathology

Pathology tests
(SPIA FHIR Valueset)

Medical
Imaging

Demo Valueset Scope:
Xray
Ultrasound
CT Scan
MRI

More content
to be added
….

Scope of today’s demo
look at a visual representation of the terminology value sets when generating a request

Demo

An example visualisation of:

- the data model (AUeReqDI)
- National eRequesting terminology

in the context of a CSIRO SMART on FHIR form component

  - Showing test selection component, one example visualisation
  - Agnostic of system implementation

Demo

eRequest SMART on FHIR

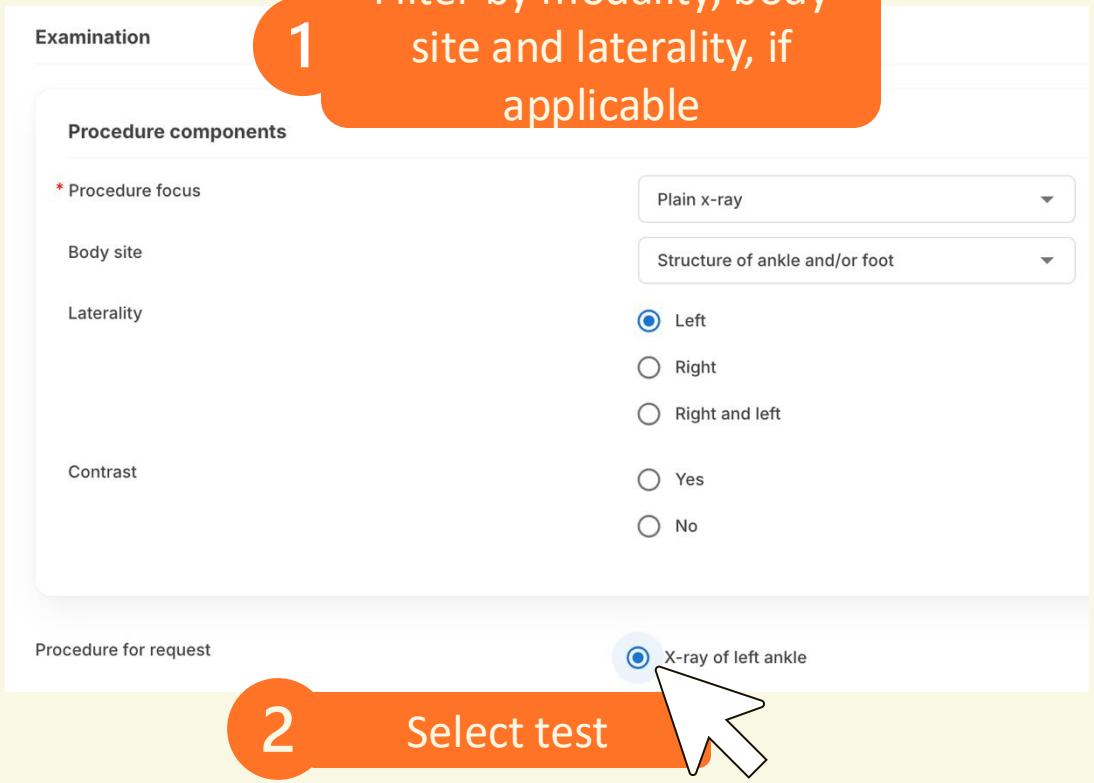
Procedure terminology selection example

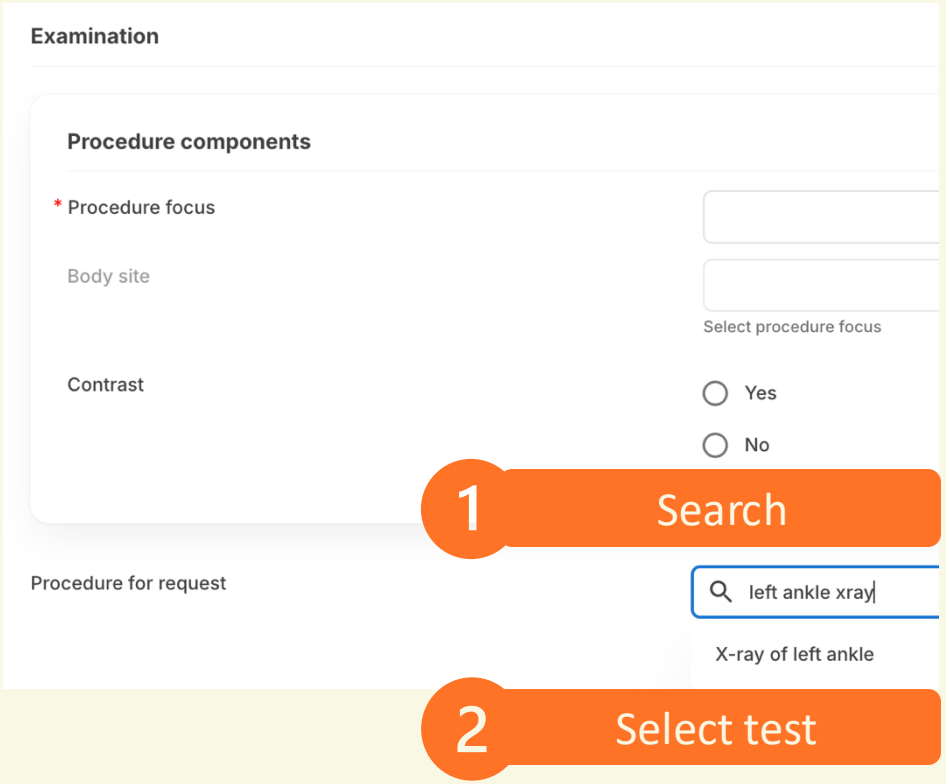
Medical Imaging eRequest Demo Examples

Select to filter

OR

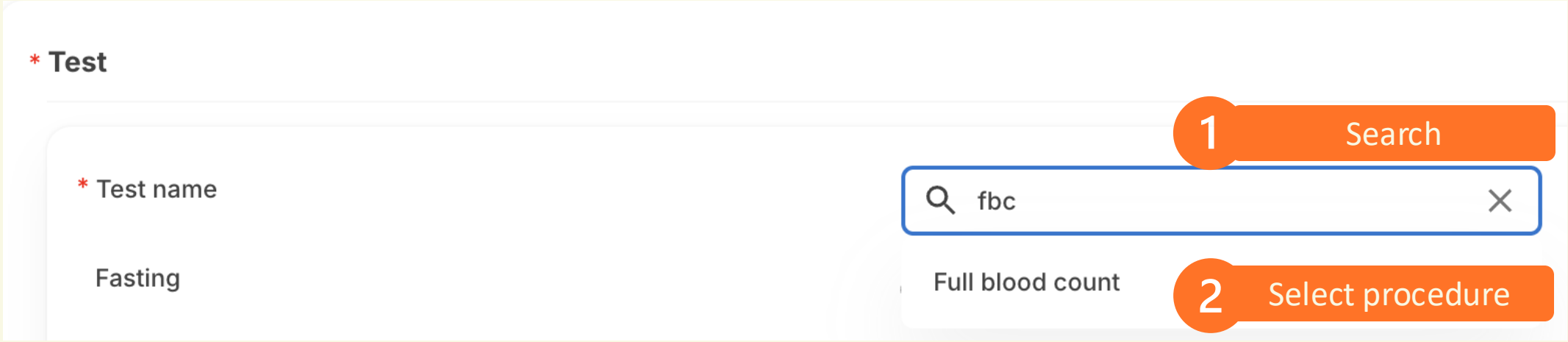
Search to filter





Sparked HL7 FHIR

Pathology eRequest Demo Example



eRequest Terminology Demo Link

go.csiro.au/FwLink/e-request-form

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Example search list

Test	Multifield input				Single field input
	Test focus	Body site	Laterality	Contrast	Example search term
X-ray of chest	Plain x-ray	Structure of thorax (search: thor)			cxr
X-ray of left femur	Plain x-ray	Bone structure of femur (search: femur)	Left		x fem
CT of acromioclavicular joint	Computed tomography	Acromioclavicular joint structure (search: clav)	Right		ct ac r
MRI of bladder with contrast	Magnetic resonance imaging	Urinary bladder structure (search: bladder)		Yes	mri bla con
MRI of colon	Magnetic resonance imaging	Colon structure (search: col)			mri col
MRI of prostate with contrast	Magnetic resonance imaging	Prostatic structure (seach: pros)		Yes	mri pro con
Fluoroscopy guided left nephrostomy	Fluoroscopy	Kidney structure (search: kid)	Left		left neph f
Ultrasound guided left nephrostomy	Ultrasound	Kidney structure (search: kid)	Left		left neph ul
Ultrasound of right Achilles tendon	Ultrasound	Structure of Achilles tendon (search: ach)	Right		ul ach r
Coronary angiography	Angiography	Coronary artery structure (search: cor)			cor ang

Workshop 4: Activity 1 – eRequesting Nationally Standardised Terminology Catalogues (20mins + 10mins report back)

- Each table will discuss having nationally standardised terminology catalogues
  - Benefits
  - Challenges
  - Opportunities
  - Risks

Document your key points on the worksheet, and once time is up, report back your key findings to the group

As a **group** at your table

Workshop 4: Activity 2 – eRequesting Nationally Standardised Terminology Catalogues – **Support Requirements** (10mins + 10mins report back)

Each table will discuss the support needed to adopt nationally standardised terminology catalogues.

Write your expectations and recommendations of each stakeholder, then report back to the group.

As a **group** at your table

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Menti

Sparked Terminology Survey

Sparked is seeking feedback to improve our understanding of the requirements for supporting the use of national terminology catalogues for Pathology and Radiology tests in systems that implement the AU eRequesting IG

Take the survey here:
https://forms.office.com/r/A7x03LV3j3

To complete later

AU eRequesting Terminology Requirements for Pathology and Radiology Test Catalogues

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Preliminary Terminology requirements survey findings

Findings

Various systems are used for creating and filling requests

Current Terminology requirements vary between jurisdictions and provider systems (eg. LIS).

Mapping between external and internal codes – requires expertise

Need for nationally agreed terminology sets

Users report interacting differently by selecting standard procedures, separate fields for modality/body site and free text

Enhancements needed to support catalogues for Rad/Path including management of unrecognised codes and standardised test panels

Next Steps

Consolidate findings

Share findings with relevant stakeholders (eg. feedback to TDG)

Review options for progressing nationally standardised catalogues

Continue to iterate on terminology content

AUeReqDI R1 Draft for Comment

- Draft for Comment now closed
- Currently working through comment and feedback
- 26 submissions received
  - Group and individuals
  - Government, Health or care providers, industry peak bodies, software vendors and consultants
- 110+ feedback items

- Due to be published October 2024

Lunch

Back at 1:30pm

Quick rewind back to yesterday

Workshop 2: Activity 2 - Australian Patient Summary Release 1 detailed data group scoping

- As a group, answer the questions on the worksheets for each of the data groups.
- Should we?
  - Use the AUCDI R1 as is for AU PS R1
  - Expand AUCDI R1 to include additional data groups/elements?
  - Proceed with proposed approach
  - Suggest an alternative approach

As a **group** at your table

Data groups we missed:

Pregnancy and Adverse reaction risk (allergies and intolerances)

Quick rewind back to yesterday

Workshop 2: Activity 2 - Australian Patient Summary Release 1 detailed data group scoping

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As a **group** at your table

Data groups we missed:

Pregnancy and Adverse reaction risk (allergies and intolerances)

Chronic Disease Management – real time, integrated shared care planning

Objectives

- Identifying and prioritising the scope of a AUCDI R2 to support Chronic Disease Management (real-time, shared care planning)

Introduction

DOHAC

Allied Health Perspective

Jackie O’Connor (AHPRA)

Chronic Disease Management & Allied Health Professionals

Jackie O’Connor – Digital Health Program Manager

AHPA Ordinary Members

audiology australia

AARPN

Australasian College of Paramedic Practitioners

Human Genetics Society of Australasia

ANZCP
Australian and New Zealand College of Perfusionists

AAPi
Australian Association of Psychologists Inc

AASW
Australian Association of Social Workers

Australian Chiropractors Association

ADEA
Your trusted partner in diabetes care

Australian Music Therapy Association

The Australian Orthotic Prosthetic Association

Australian Physiotherapy Association

Apoda
Australian Podiatry Association

APS
Australian Psychological Society

Australian Society of Medical Imaging and Radiation Therapy

ANZACATA
The Australian, New Zealand and Asian Creative Arts Therapies Association

Chiropractic Australia

Dietitians Australia

ESSA
Exercise & Sports Science Australia

Occupational Therapy Australia

Optometry Australia

orthoptics australia

osteopathy Australia

Pedorthic Association of Australia

PACFA
Psychotherapy and Counselling Federation of Australia

RCAA
Rehabilitation Counselling Association of Australasia

Speech Pathology Australia

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Our Affiliate Members

appta
AUSTRALASIA PACIFIC PLAY THERAPY ASSOCIATION

Australasian Lymphology Association

ACA
AUSTRALIAN COUNSELLING ASSOCIATION

australianhand therapyassociation ltd

asorc
AUSTRALIAN SOCIETY OF REHABILITATION COUNSELLORS

dtaa
Dance Movement Therapy Association of Australasia Inc.

DHAA
Dental Hygienists Association of Australia Ltd.

HAASA
LABORAMUS UT AUDIATIS

MA
MYOTHERAPY ASSOCIATION AUSTRALIA™

Play Therapy
PRACTITIONERS ASSOCIATION

Spiritual Health Association

AUSTRALIAN SOCIETY OF DERMAL CLINICIANS
ASDC

Who is the audience?

- Medicare funded CDM plans = 15 of 39 professions
- System additions:
  - Community health, Aboriginal medical health services, compensable schemes, imaging requests
- Broad workflows = nuanced communication
- Inefficiencies limit sharing beyond referrers and mandates

Receipt and delivery

- MHR not fit for purpose
- GP's to AHP = fax
- Email + or - password
- Secure messaging
- EMR/CIS
- Snail mail

Information shared

- Referrals received and reports provided in response
- Aged care plans = little to no input
- Medicare CDM requirements met
- 3rd party insurers = outcome measure results and guided assessment forms
- Details = practitioner discretion = enormous data diversity

Challenges & Opportunities

CHALLENGES	OPPORTUNITIES
Lack of information = clinical risk & costly delays	Limit delays in treatment provision & optimise outcomes Decrease costs for various stakeholders
Return communication not addressed	Increased levels of coordinated care and understanding of decisions made
Limited care plans produced	Increased use and communication of information
Accuracy & currency concerns Language interpretation difficulties Siloed information remains	One easy to interpret source of truth
Potentially conflicting goals with limited opportunity for consumer vs practitioner differentiation	1 set holistic goals informed by consumer, aligned with treatment plans

Challenges & Opportunities

CHALLENGES	OPPORTUNITIES
Loss of documents = delays & funding ineligibility	Accessible documentation
Privacy & security concerns	Ability for consumers to manage access
Confused consumers	Empowered consumers

Current state = not ok

- System level data required:
  - Policy development
  - Fill research gaps
  - Informed choice
- Holistic data standards needed to make digital integration valuable to & viable for AHPs

GP Perspective

Steven Kaye

•Chronic Disease Management:

•A General Practice perspective

Dr Steven Kaye

RACGP

- Chronic Disease Management
- (CDM)

RACGP

• Introduction – CDM overview

- Increasingly, with an ageing population and improved health care intervention, more people are living with some level of **Chronic Disease** than ever before.
- Improved knowledge in health generally has led to an explosion of diagnoses & therapies (pharmacological and others) and **improved outcomes** for the individual and across most of population groups
- Evidence indicates that best **chronic illness care** is ideally structured, integrated and multidisciplinary.
- Direct **measurement** of outcomes have traditionally been difficult to obtain with inconsistent data, often recorded in traditional, analogue, non-shared forms.
- **Review** periods, Feedback & Preventive Care are often ill-defined and seen as a burden to the patient (rather than an opportunity to tweak management and enhance data tracking)

• Challenges

- **Communications** across the care team – Fax? Paper? Static document?
- **Mindset** of Clinicians – data measurement (incl outcomes) and Population Health trends seem mysterious
- Current **templates** & other documents used in the process
- The complexity of creating **meaningful** care plans that are up-to-date and individually personalized
- Keeping track of what everyone on the care team is doing and ensuring duty-of-care responsibilities are managed – **Coordinated care**
- Regular review and **follow-up** and getting patients back for a visit they may think is unnecessary
- The **red tape** of Medicare requirements, regardless of “best practice”, time-consumption & outcomes

• Opportunities

- There is a clear need for technology to support the sharing & **integration** of information and data collection a part of chronic disease management

- Technical solutions can create the **flow of information** *connected to the individual* across the healthcare system

- **Education** (benefits & techniques of authorship of high quality data for improved patient outcomes) and available **Incentives** across all of health, promoting an integrated, multidirectional patient-centered system

- **Data Quality** & Consistency is imperative:

- development of “living” documents to be shared across clinical & analytic disciplines,
- CDS (Clinical Decision Support) to be activated,
- Data extraction/interrogation, analysis & system development to be meaningful
- KPI’s and meaningful outcome data at individual/practice/region level could becomes a reality.

Questions, Discussion and Thanks.

Steven Kaye

Healthy Profession.
Healthy Australia.

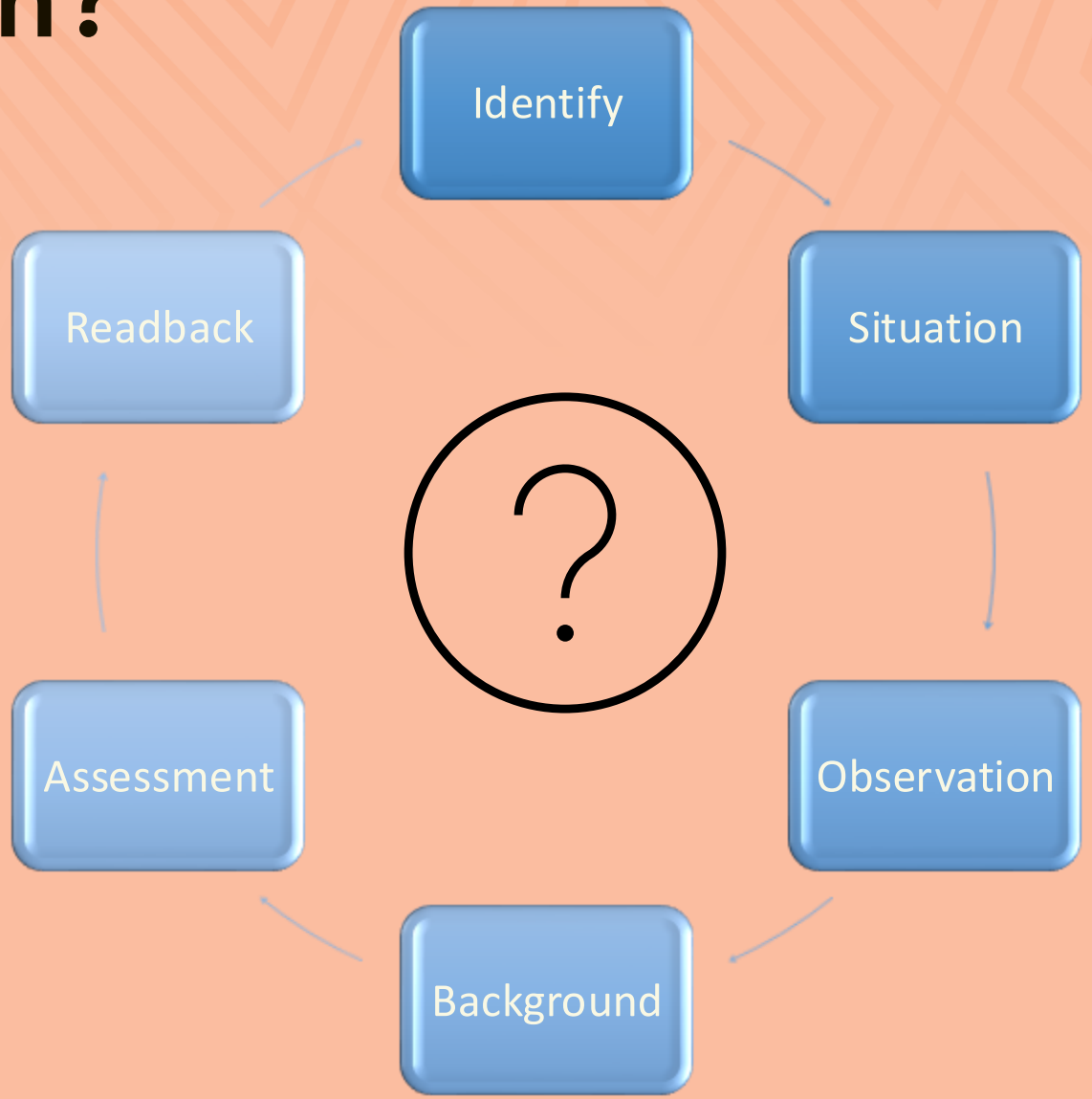
Perspective

Nyree Taylor

What is a CarePlan?

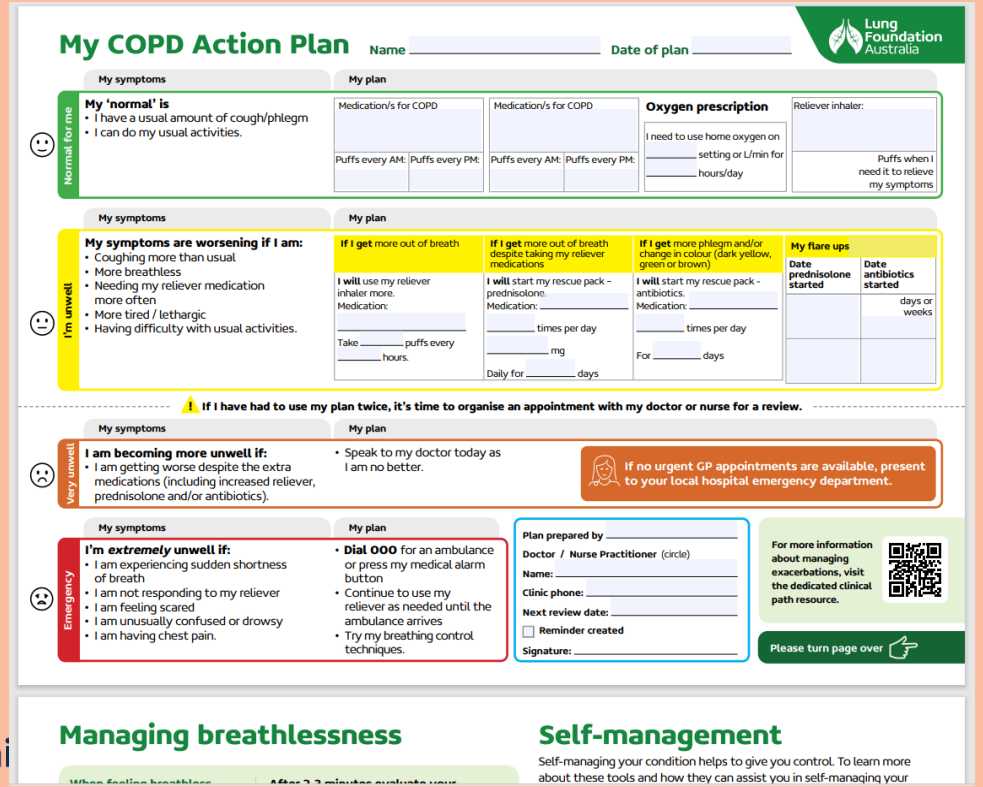
Three key points to consider when Care Planning for Victorian Indigenous populations

1. Individualised person-centred care plan
2. Standardised data to inform continuity of care
3. Human ‘life’ care planning vs Medicare Care planning



COPD & Continuity of Complex Care

- COPD Victorian Indigenous populations
  - Different data ‘picture’ to highest incidence population compared with National data set
  - Data is incomplete in information – smoking ‘cessation’.
- COPD & 715
  - Currency of data is not ‘of value’ and is too expensive to maintain at local level
  - Granularity of data in care plans lacks continuity of care/meaning



My COPD Action Plan

Name _____ Date of plan _____

Lung Foundation Australia

My symptoms | My plan

Normal for me

My ‘normal’ is
- I have a usual amount of cough/phlegm
- I can do my usual activities.

Medication/s for COPD: Puffs every AM: ____ Puffs every PM: ____

Medication/s for COPD: Puffs every AM: ____ Puffs every PM: ____

Oxygen prescription: I need to use home oxygen on ____ setting or L/min for ____ hours/day

Reliever inhaler: Puffs when I need it to relieve my symptoms

My symptoms | My plan

I’m unwell

My symptoms are worsening if I am:
- Coughing more than usual
- More breathless
- Needing my reliever medication more often
- More tired / lethargic
- Having difficulty with usual activities.

If I get more out of breath: I will use my reliever inhaler more. Medication: _____ Take ____ puffs every ____ hours.

If I get more out of breath despite taking my reliever medications: I will start my rescue pack – prednisolone. Medication: _____ ____ times per day ____ mg Daily for ____ days

If I get more phlegm and/or change in colour (dark yellow, green or brown): I will start my rescue pack - antibiotics. Medication: _____ ____ times per day For ____ days

My flare ups: Date prednisolone started | Date antibiotics started ____ days or weeks

If I have had to use my plan twice, it’s time to organise an appointment with my doctor or nurse for a review.

My symptoms | My plan

Very unwell

I am becoming more unwell if:
- I am getting worse despite the extra medications (including increased reliever, prednisolone and/or antibiotics).

- Speak to my doctor today as I am no better.

If no urgent GP appointments are available, present to your local hospital emergency department.

My symptoms | My plan

Emergency

I’m *extremely* unwell if:
- I am experiencing sudden shortness of breath
- I am not responding to my reliever
- I am feeling scared
- I am unusually confused or drowsy
- I am having chest pain.

- **Dial 000** for an ambulance or press my medical alarm button
- Continue to use my reliever as needed until the ambulance arrives
- Try my breathing control techniques.

Plan prepared by _____
Doctor / Nurse Practitioner (circle)
Name: _____
Clinic phone: _____
Next review date: _____
☐ Reminder created
Signature: _____

For more information about managing exacerbations, visit the dedicated clinical path resource.

Please turn page over

Managing breathlessness

Self-management

Self-managing your condition helps to give you control. To learn more about these tools and how they can assist you in self-managing your

Reference: https://lungfoundation.com.au/resources/copd-action-plan/ accessed 09/09/2024

What is missing?

- Source of truth data
  - Currency
  - Accuracy
  - Click fatigue
  - Forms
  - Good local stories
    - Programs such as TIS
    - Prevention and early intervention measures – highlighting the success of these

Perspective

Tim Blake

Menti

Workshop 5

Chronic disease management

Objectives - Workshop 5: Chronic Disease Management

- Identifying the data groups required to support real-time shared care planning and chronic disease management
- Understanding data requirements in the chronic disease management workflow

Chronic Disease Management - Use Cases Collected

Continuity & Co-Ordination of Care Across Time/Location/ Provider Type	Remote Patient Monitoring	Advance Care Directives	Medication Management
Patient Care Management Plan (e.g. Mental Health Plan, Chronic Disease Plans)	Setting Goals of Care and Follow up	Risk Management	Value Based Healthcare
Patient Self Management	Public Health Initiatives		

Summary of Chronic Disease Management use cases identified from both workshops

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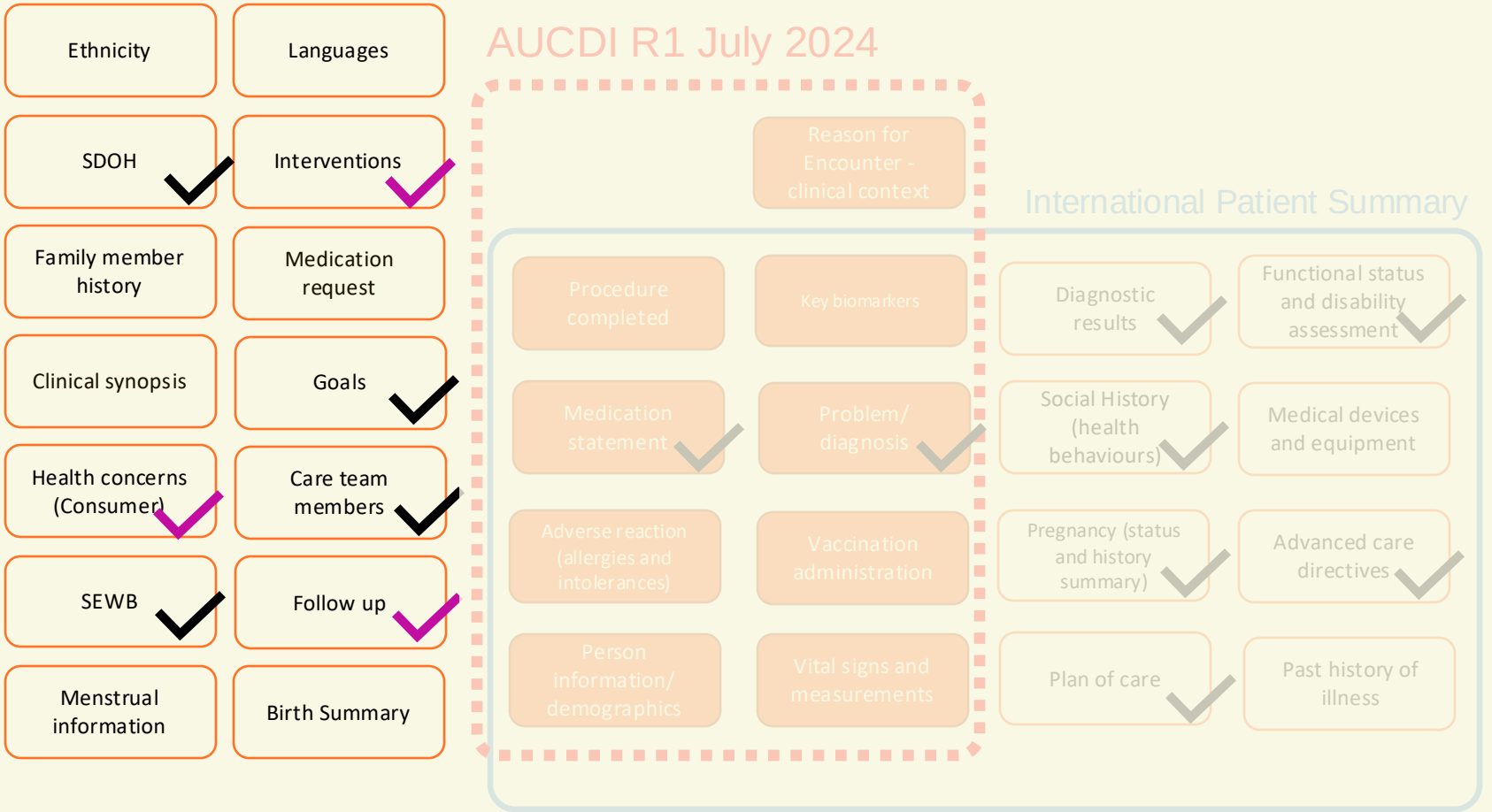
AUCDI backlog focused on Chronic Disease Management (CDM)

✓ Priority based on F2F meetings

✓ Related to plan of care/care planning



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Pan Canadian Health Data Content Framework

Integrated care plan

The following data elements pertain to the plan to meet the health, wellness, care and service needs and objectives of a person.

Data element name	Data element definition
Reviewer First Name	The first name of the individual who has the responsibility for reviewing, maintaining or updating this information
Reviewer Last Name	The last name of the individual who has the responsibility for reviewing, maintaining or updating this information
Entry Date	The date that the care plan entry was made
Identified Needs	Information about the health needs, problems or concerns that the integrated care plan aims to address
Person Strengths	The person's strengths and assets relating to their goals and hopes about their health and well-being
Person Goals and Wishes	A description of a person's desired outcomes of their care
Social Determinant of Health Goals	A description of the person's goals and wishes regarding social determinants of health-related concerns, conditions or diagnoses (e.g., food security)
Person Treatment Preferences	A description of a person's goals, preferences and priorities for care and treatment in case that person is unable to make medical decisions because of a serious illness or injury (e.g., cardiopulmonary resuscitation)
Safety Considerations	Information about specific safety measures that are required to ensure the safety of the person (e.g., home safety features, maintenance of equipment and furnishings)
Other Required Services	Information about the specific services and programs that are required to address physical, psychosocial and/or cultural needs
Person Responsibilities	The person's responsibilities regarding their care and health (e.g., taking medications, informing the team of changes in their health status)
Team Responsibilities	The team members' responsibilities, including those of caregivers, in the delivery of care or services
Caregiver Involvement	An indication of whether a member of the person's family or social circle is currently involved in the person's care plan
Timeframe for Goals	The time frame required to achieve the goals and wishes identified within the care plan, as determined by the person
Agreement With Care Plan	Indicates whether the plan was discussed with and agreed to by the person or legitimate representative
Treatment Recommendation	A treatment recommendation that aligns with the person's goals and wishes
Given Recommendation Date	The date of each recommendation included in the care plan; however, it may be that the plan is given on a single date with multiple recommendations in the same plan
Other Care Planning Documents	References to other care-planning documents, including the type, location and date
Integrated Care Plan Summary	Indicates which parts of the medical record are used to inform the integrated care plan (e.g., immunizations, procedures, encounter)
Next Planned Review Date	The date when the care plan will be reviewed next
Care Plan Evaluation	An assessment of whether the person is achieving their goals and wishes related to their care plan

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Team Care Arrangement plan example

TEAM CARE ARRANGEMENTS - MBS ITEM No. 723

Patient's Name: <<Patient Demographics:Full Name>> **Date of Birth:** <<Patient Demographics:DOB>>

Contact Details:
<<Patient Demographics:Full Address>>

Medicare or Private Health Insurance Details:
<<Patient Demographics:Medicare Number>>
<<Patient Demographics:Health Insurance>>

Details of Patient's Usual GP:
<<Doctor:Name>>
<<Doctor:Full Address>>

Details of Patient's Carer (if applicable):

Date of the last Care Plan / Team Care Arrangements (if done): <<Date of last Care Plan/TCA>>

Other notes or comments relevant to the patient's Team Care Arrangements:

PAST MEDICAL HISTORY

FAMILY HISTORY

<<Clinical Details:Family History>>

MEDICATIONS

<<Clinical Details:Medication List>>

ALLERGIES

TEAM CARE ARRANGEMENTS - MBS ITEM No. 723

Goals - changes to be achieved	Required treatments and services including patient actions	Specific arrangements for treatments/services (when, who, and contact details)

Copy of Team Care Arrangements offered to patient? <<Copy of TCA offered to patient?>>

Team Care Arrangements added to the patient's records? <<TCA added to patient record?>>

Copy / relevant parts of the Team Care Arrangements supplied to other providers? <<Copy of TCA supplied to other providers?>>

Referral forms for Medicare allied health and dental care services completed? <<Referral forms for Medicare AHPs completed?>>
[For referral forms call 1800 067 307, go to www.hic.gov.au/providers/forms or look under "Supplied" templates]

Date service was completed: <<Date service completed>> **Proposed Review Date:** <<Review date (6 months recommended)>>

I have explained the steps and any costs involved, and the patient has agreed to proceed with the Team Care Arrangements. <<Steps and costs explained, patient agreed>>
The patient also agrees to the involvement of other health providers and to share their clinical information (without / with restrictions). <<Patient agrees to AHPs and sharing information>>

GP's Signature: _____ Date:_____

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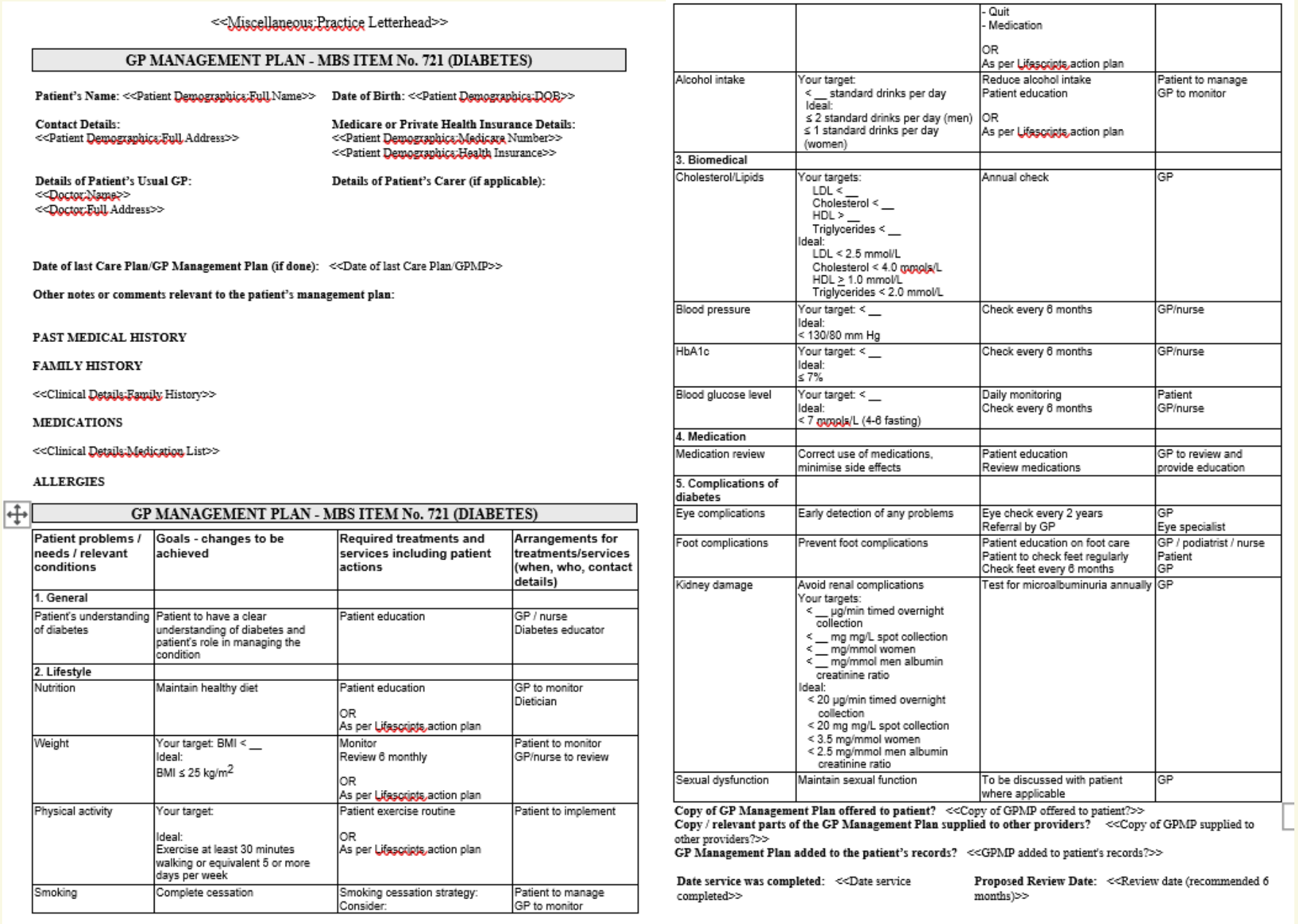
GP Management Plan Example



<<Miscellaneous:Practice Letterhead>>

GP MANAGEMENT PLAN - MBS ITEM No. 721 (DIABETES)

Patient's Name: <<Patient Demographics:Full Name>> **Date of Birth:** <<Patient Demographics:DOB>>

Contact Details:
<<Patient Demographics:Full Address>>

Medicare or Private Health Insurance Details:
<<Patient Demographics:Medicare Number>>
<<Patient Demographics:Health Insurance>>

Details of Patient's Usual GP:
<<Doctor:Name>>
<<Doctor:Full Address>>

Details of Patient's Carer (if applicable):

Date of last Care Plan/GP Management Plan (if done): <<Date of last Care Plan/GPMP>>

Other notes or comments relevant to the patient's management plan:

PAST MEDICAL HISTORY

FAMILY HISTORY

<<Clinical Details:Family History>>

MEDICATIONS

<<Clinical Details:Medication List>>

ALLERGIES

GP MANAGEMENT PLAN - MBS ITEM No. 721 (DIABETES)

Patient problems / needs / relevant conditions	Goals - changes to be achieved	Required treatments and services including patient actions	Arrangements for treatments/services (when, who, contact details)
1. General			
Patient's understanding of diabetes	Patient to have a clear understanding of diabetes and patient's role in managing the condition	Patient education	GP / nurse Diabetes educator
2. Lifestyle			
Nutrition	Maintain healthy diet	Patient education OR As per Lifescripts action plan	GP to monitor Dietician
Weight	Your target: BMI < __ Ideal: BMI ≤ 25 kg/m^2	Monitor Review 6 monthly OR As per Lifescripts action plan	Patient to monitor GP/nurse to review
Physical activity	Your target: Ideal: Exercise at least 30 minutes walking or equivalent 5 or more days per week	Patient exercise routine OR As per Lifescripts action plan	Patient to implement
Smoking	Complete cessation	Smoking cessation strategy: Consider: - Quit - Medication OR As per Lifescripts action plan	
Alcohol intake	Your target: < __ standard drinks per day Ideal: ≤ 2 standard drinks per day (men) ≤ 1 standard drinks per day (women)	Reduce alcohol intake Patient education OR As per Lifescripts action plan	Patient to manage GP to monitor
3. Biomedical			
Cholesterol/Lipids	Your targets: LDL < __ Cholesterol < __ HDL > __ Triglycerides < __ Ideal: LDL < 2.5 mmol/L Cholesterol < 4.0 mmols/L HDL ≥ 1.0 mmol/L Triglycerides < 2.0 mmol/L	Annual check	GP
Blood pressure	Your target: < __ Ideal: < 130/80 mm Hg	Check every 6 months	GP/nurse
HbA1c	Your target: < __ Ideal: ≤ 7%	Check every 6 months	GP/nurse
Blood glucose level	Your target: < __ Ideal: < 7 mmols/L (4-6 fasting)	Daily monitoring Check every 6 months	Patient GP/nurse
4. Medication			
Medication review	Correct use of medications, minimise side effects	Patient education Review medications	GP to review and provide education
5. Complications of diabetes			
Eye complications	Early detection of any problems	Eye check every 2 years Referral by GP	GP Eye specialist
Foot complications	Prevent foot complications	Patient education on foot care Patient to check feet regularly Check feet every 6 months	GP / podiatrist / nurse Patient GP
Kidney damage	Avoid renal complications Your targets: < __ µg/min timed overnight collection < __ mg mg/L spot collection < __ mg/mmol women < __ mg/mmol men albumin creatinine ratio Ideal: < 20 µg/min timed overnight collection < 20 mg mg/L spot collection < 3.5 mg/mmol women < 2.5 mg/mmol men albumin creatinine ratio	Test for microalbuminuria annually	GP
Sexual dysfunction	Maintain sexual function	To be discussed with patient where applicable	GP

Copy of GP Management Plan offered to patient? <<Copy of GPMP offered to patient?>>
Copy / relevant parts of the GP Management Plan supplied to other providers? <<Copy of GPMP supplied to other providers?>>
GP Management Plan added to the patient's records? <<GPMP added to patient's records?>>

Date service was completed: <<Date service completed>> **Proposed Review Date:** <<Review date (recommended 6 months)>>

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Workshop 5: Activity 1 – Chronic Disease Management (CDM) workflow

In your group, complete the worksheet for the Data Groups

CDM Data groups

- Social Determinants of Health (SDOH)
- Interventions
- Goals
- Health concerns (consumer)
- Care team members
- Social Emotional Wellbeing (SEWB)
- Follow up

As a **group**
at your table

Workshop 5: Activity 1 – CDM Workflow considerations (20 min)

- What information is needed to support shared care for Chronic Disease Management?
  - Settings
  - Systems
  - Is this data being recorded?
    - How? Current challenges/gaps
  - What should a future state look like? What and how should it work? e.g. shared care tool
- If there are other data groups in the AUCDI backlog that SHOULD be considered for CDM, please add them to the sheet

As a **group**
at your table

CDM in AUCDI R2 - Core of the core

Social Determinants of Health

Physical activity summary
Food and nutrition summary
Sexual health summary
Gambling summary
Housing summary
Living arrangement summary
Social network summary
Transport access summary
Personal safety summary
Education summary
Occupation summary
Health access summary
Financial summary
Literacy
Communication capability
And ..?

Health concerns (consumer)

Goals

Patient, clinical, carer, ?

Interventions

International Classification of Health Interventions (ICHI)
ICHI covers interventions carried out by a broad range of providers across the full scope of health systems and includes interventions on: diagnostic, medical, surgical, mental health, primary care, allied health, functioning support, rehabilitation, traditional medicine and public health.

How do we approach this?

Social Emotional Wellbeing

Follow-up

Recalls and reminders, post op follow up, ?

Care team members

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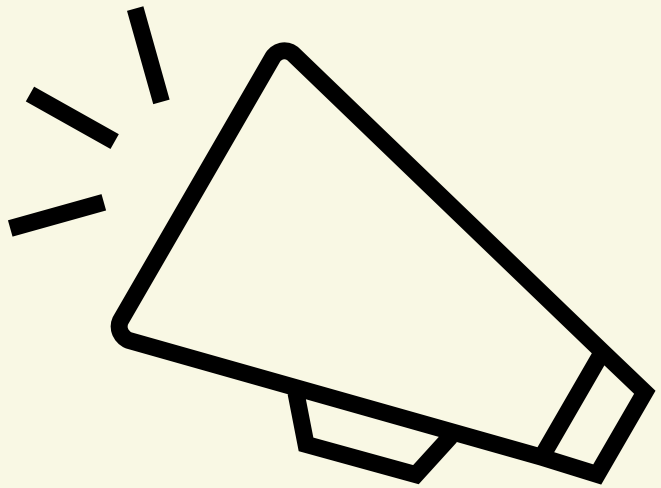
Report back time!

Please tell us your table's agreed inclusions and justifications

10 min



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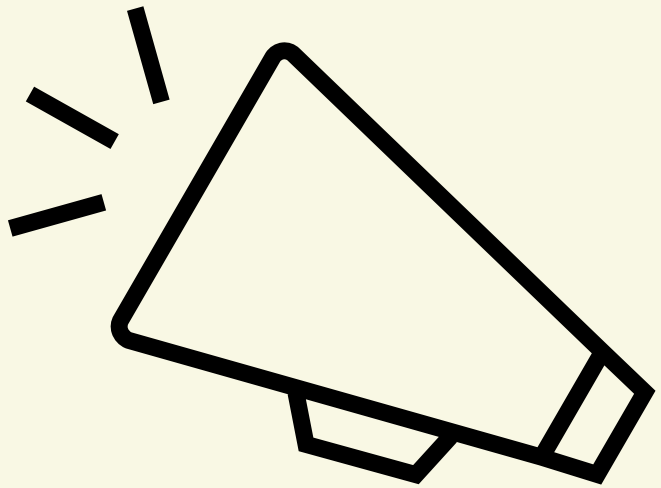
Workshop 5: Activity 2 – Chronic Disease Management AUCDI R2 Scoping (15min)

- Which **Chronic Disease Management** data groups do we prioritise for inclusion in the **second release** of AUCDI?
  - Consider
    - Availability of structured and coded information
    - Feasibility
    - Data quality
    - Usefulness
  - Remember ‘Core of the Core’

- As a group at your table, using the worksheet, identify which data groups and why they should be in AUCDI R2

Report back time!

Please tell us your table's agreed inclusions and justifications
(10 min)



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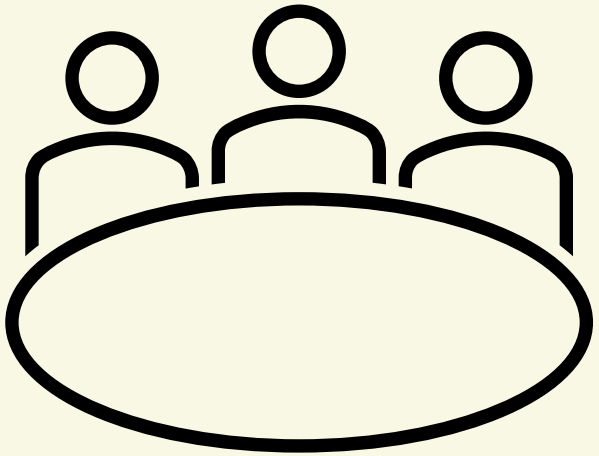
Discuss as a table!

As a group, are your priorities still the same?

(5 min)



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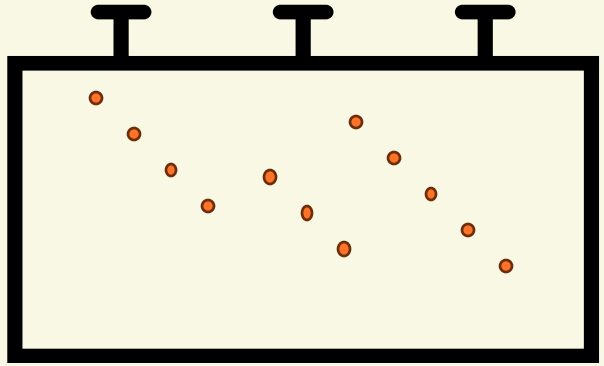
Sticker up!

Each table places their priority stickers on the big voting sheet on the wall.



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Afternoon tea

Workshop 5

Chronic disease management continued

Objectives - Workshop 5: Chronic Disease Management continued…

- Identifying the data groups required to support real-time shared care planning and chronic disease management
- Identifying what additional work on AUCDI is needed to support chronic disease management

Activity 3 – Chronic Disease Management AUCDI Release 2 detailed data group scoping

- For each of the agreed data groups in for Chronic Disease Management in AUCDI R2, there is a worksheet which provides (where relevant)
  - Some background information
  - Mindmaps representing the roadmap of where that data group could go
  - Mindmaps or text representing a proposed approach
  - Discussion questions
- As a group, answer the questions on the worksheets for each of the data groups.

Activity 3 – Chronic Disease Management AUCDI Release 2 detailed data group scoping

- As a group, answer the questions on the worksheets for each of the data groups.

As a **group**
at your table

Menti

Sparked Evaluation

Sparked Evaluation

CSIRO Evaluation

CSIRO Evaluation Team

to ensure Sparked is fit for purpose and is serving the community's needs

DoHAC Evaluation

Independent external evaluation

to examine the broader Sparked deliverables and policy perspectives

Why should you participate?

- Influence what's needed to improve the community process
- Support our agile way of working so we can adapt
- Contribute to the global benchmark of what success looks like for a national accelerator
- Shape the future direction for creation and adoption of FHIR standards in Australia

Sparked HL7 FHIR

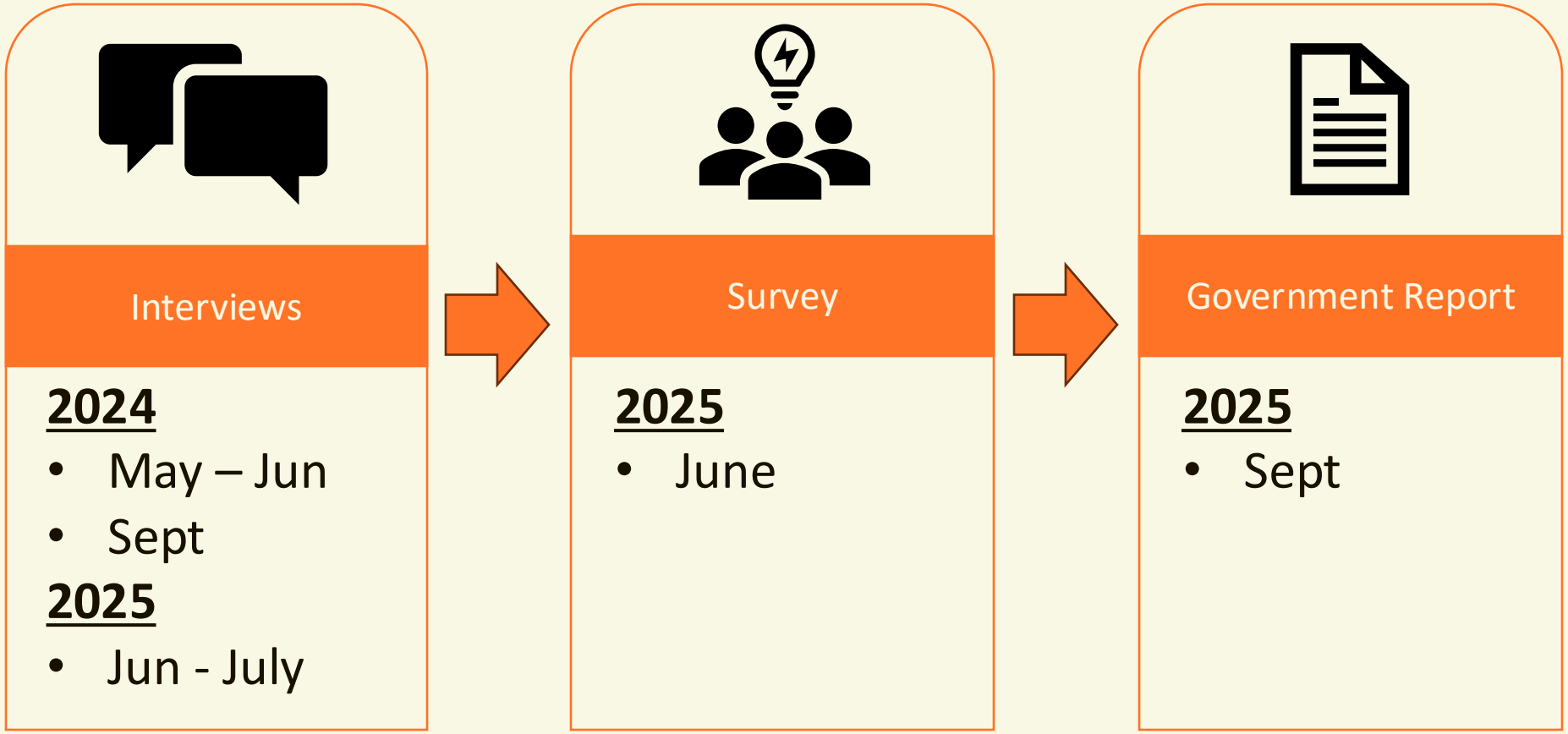
CSIRO Sparked Evaluation Update

The CSIRO AeHRC is continuously evaluating the effectiveness of Sparked to inform improvements and changes to the accelerator

Sparked HL7 FHIR

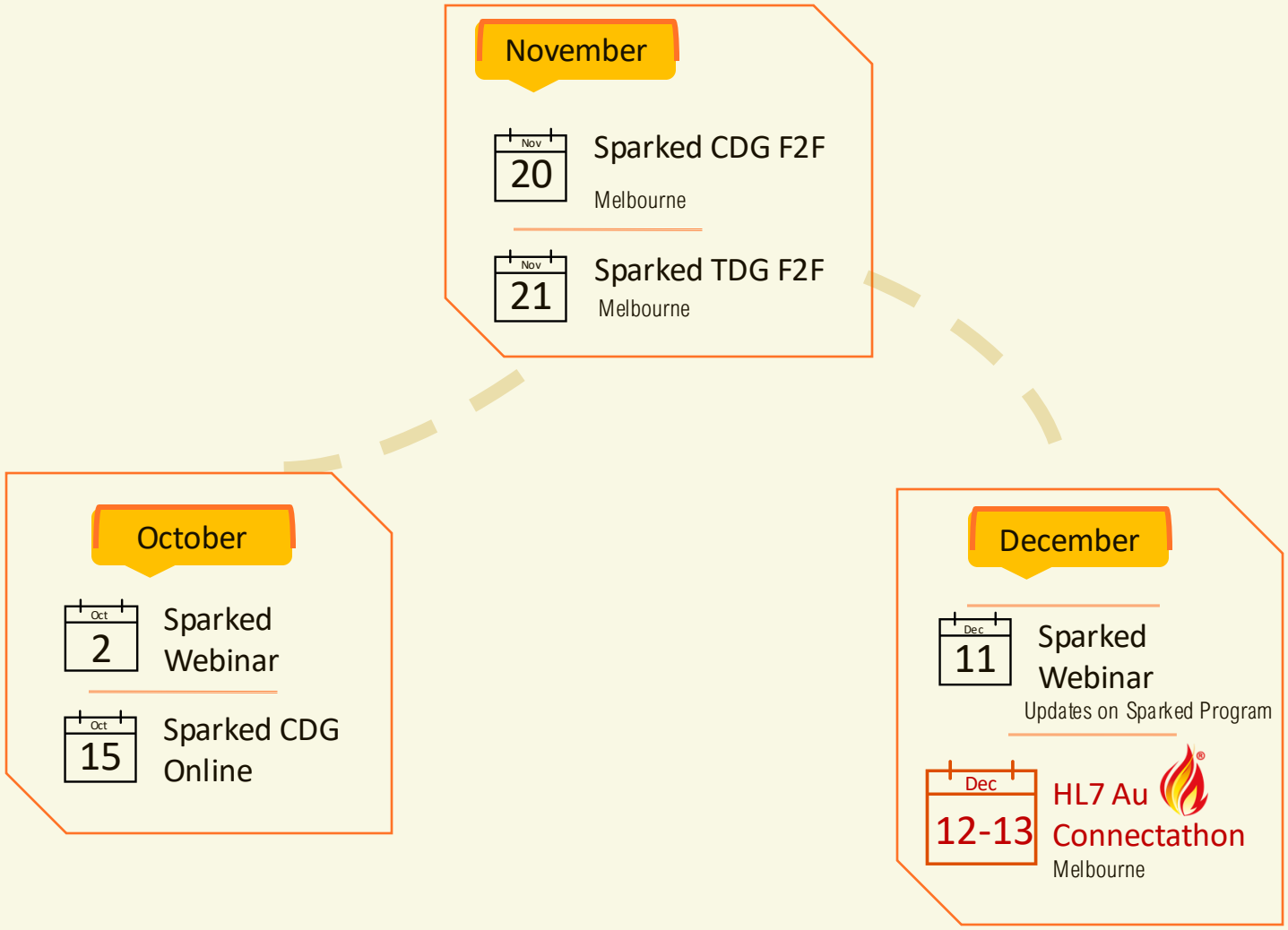
DoHAC Evaluation Update

DoHAC have selected Voronoi as an independent evaluator of the Sparked accelerator



Sparked HL7 FHIR

Upcoming Events 2024



Sparked
HL7 FHIR

Menti

AU FHIR Accelerator

Register for Sparked

Thank you


Thank you